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MEDICAID MEMO

TO: All In State Hospitals, Rehab Hospitals, Physicians, Nurse Practitioners, Chiropractors, Podiatrists, Optometrists, Opticians, Dentists, Dental Clinics, Ambulatory Surgical Centers, Health Departments, Federally Qualified Health Centers, Rural Health Clinics, Prosthetics Providers, Independent Labs, Out of State Rehab Providers, Out of State DME/Supply Providers, Out of State Hospitals, Out of State Physicians, Out of State Dental Providers, and Out of State Lab Providers Participating in the Virginia Medical Assistance Programs

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 03/09/2012

SUBJECT: Services Currently Reviewed by DMAS' Medical Support Unit Moving to KePRO for Review and New Procedure Codes Requiring Service Authorization — ***Effective, April 1, 2012***

The purpose of this memorandum is to notify providers that certain services currently reviewed by DMAS' Medical Support Unit (MSU) will be reviewed by Keystone Peer Review Organization (KePRO), DMAS' service authorization contractor. KePRO will begin accepting requests, regardless of the dates of service, on April 1, 2012. KePRO will provide web based training sessions for providers starting March 19, 2012. Providers may access these training sessions by going to http://dmas.kepro.com and clicking on the *Training* tab.

The services that require service authorization through KePRO effective April 1, 2012 are attached to this memo. Provider Manuals will be updated and posted on DMAS and KePRO websites prior to April 1, 2012.

New Procedure Codes That Will Require Service Authorization, Beginning April 1, 2012

Effective April 1, 2012 the procedure codes on the attached spreadsheet marked with an asterisk and bolded will require service authorization prior to claims submission to obtain payment for services. **There is no retroactive authorization period for these services, except for retroactive eligibility determination. These codes require service authorization effective April 1, 2012 prior to rendering services. The only instance KePRO will approve services retroactively on and after April 1, 2012 for these new codes requiring service authorization is when the provider demonstrates retroactive Medicaid eligibility determination for members.**

KePRO will allow retroactive reviews for service requests submitted through June 30, 2012 for all other procedure codes on the attached list that are not bolded or marked with asterisk. Effective July 1, 2012 KePRO will not authorize requests retroactively for these procedure codes, regardless of the dates of

service. **The only instance KePRO will approve services retroactively on and after July 1, 2012 for the codes not bolded or marked with asterisk on the spreadsheet is when the provider demonstrates retroactive Medicaid eligibility determination for members.**

General Information Regarding Service Authorization

Service authorization (Srv Auth) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS member by a DMAS enrolled provider prior to service delivery and reimbursement. Some services do not require authorization and some may begin prior to requesting authorization. Providers are instructed to refer to the appropriate provider manual to determine when service authorization is required for specific procedures and to check the DMAS web portal for the most current fee file. The fee file indicates whether a specific HCPCS/CPT requires service authorization for DMAS covered services.

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the member's continued Medicaid/FAMIS eligibility, the provider's continued eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual member, a provider, a service code, an established quantity of units, and for specific dates of service.

Retrospective review will be performed when a provider is notified of a patient's retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain service authorization prior to billing DMAS for these services. Providers must request a service authorization for retrospective review as soon as they are aware of the member's Medicaid eligibility determination.

KePRO's website has information related to the service authorization processes for all DMAS programs they review. Fax forms, service authorization checklists, trainings, and much more are on KePRO's website. Providers may access this information by going to http://dmas.kepro.com.

Submitting Requests to KePRO, *effective April 1, 2012*

All submission methods and procedures are fully HIPAA-compliant and in accordance with other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests submitted to KePRO.

KePRO will accept requests through direct data entry (DDE) or by fax. The preferred method is by DDE through KePRO's provider portal, Atrezzo Connect. To access Atrezzo Connect on KePRO's website, go to http://dmas.kepro.com. For DDE requests, providers must use Atrezzo Connect Provider Portal.

Provider Registration is Required to use Atrezzo Connect

The registration process for providers happens immediately on-line. From http://dmas.kepro.com, providers not already registered with Atrezzo Connect may click on "*First Time Registration*" to be prompted through the registration process. Newly registering providers will need their 10-digit National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount.

The Atrezzo Connect User Guide is available at http://dmas.kepro.com: Click on the *Training* tab, then the *General* tab.

Providers with questions about KePRO's Atrezzo Connect Provider Portal may contact KePRO by email at atrezzoissues@kepro.com.

For service authorization questions, providers may contact KePRO at providerissues@kepro.com. KePRO can also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

Faxing Requests to KePRO

Providers must use the specific fax form listed below when requesting services listed on the attachment to this memorandum. If the fax form is not accompanied by the request, KePRO will reject the request and the provider must resubmit the entire request with the correct fax form. The DMAS 351 *(Procedures/Devices Service Authorization Request Form)* and DMAS 363 *(Outpatient Service Authorization Request Form)* are attached to this memorandum. Forms are also available on KePRO's website at http://dmas.kepro.com. Providers may click on the "*Forms"* tab to view a listing of all KePRO fax forms, labeled by form number and service type.

Service Type	Fax Form to Use	Procedure Code
0300 Organ Transplant Services	DMAS 351	· See list attached to this memorandum · Includes out of state services for procedure codes on attached list
0302 Surgical Procedures	DMAS 351	
0303 Prosthetics	DMAS 363	
0304 Medical Device, services/maintenance	DMAS 351	

Timeliness of Submission by Providers, Effective July 1, 2012 and Forward

All requests for services must be submitted prior to services being rendered. KePRO will allow a grace period through June 30, 2012 for providers to submit requests for services already rendered. **This grace period only applies to the procedure codes attached to this memo. Effective July 1, 2012 there will be no retroactive authorization.** This means that if the provider is untimely submitting the request, KePRO will review the request and make a determination from the date it was received. The days/units that were not submitted timely will be denied, and appeal rights provided.

Timeliness for Organ Transplants does not apply. Requests must be submitted to KePRO as soon as the need is known and prior to performing the actual transplant.

If a provider had a claims denial due to the absence of service authorization, KePRO will not perform retroactive authorization effective July 1, 2012. Providers may appeal the claims denial through DMAS.

Processing Requests at KePRO

KePRO will approve, pend, reject, or deny requests for service authorization. When a final disposition is reached, KePRO will notify the member and the provider of the status of the request through the Medicaid Management Information System (MMIS) letter generation process. For organ transplants, an additional letter will be faxed to the provider.

Providers who have received an approved service authorization prior to April 1, 2012 from DMAS' Medical Support Unit will receive an additional letter generated by the MMIS. This letter is to ensure that all approved service authorizations are accessible to KePRO. These letters will be mailed by March 31, 2012.

If there is insufficient medical necessity information to make a final determination, KePRO will pend the request back to the provider requesting additional information. If the information is not received within the time frame requested by KePRO, the request will automatically be sent to a physician for a final determination with all information that has been submitted. In the absence of clinical information, the request will be submitted to the supervisor for review and final determination. Providers and members are issued appeal rights through the MMIS letter generation process for any adverse determination. Instructions on how to file an appeal is included in the MMIS generated letter.

If services cannot be approved for members under the age of 21 using the current criteria, KePRO will then review the request by applying EPSDT criteria.

Specific Information for Service Type 0300 Organ Transplants

KePRO will review requests for Kidney, Liver, Bone Marrow and Stem Cell, Heart, Lung, Heart/Lung for all Medicaid/FAMIS members, and Pancreas and Intestinal and Multi-visceral transplants only for Medicaid members under 21 years of age. Providers must submit requests to KePRO as soon as the provider is aware of the need for the transplant and prior to actual transplant procedure. Organ transplant services will be reviewed by KePRO within three business day of the submission. If there is insufficient information submitted on the request, the request will be pended and sent back to the provider with a time frame to respond. If the provider does not respond to the pended request for clinical information, or responds past the time frame given, the request will automatically be sent to a physician for review of all information that has been submitted and a final determination will be made. **A separate request for the inpatient hospitalization must be submitted to KePRO within one business day of the actual inpatient hospitalization.** Note that a service authorization for the inpatient admission is not required for out-of-state (non-participating enrolled) facilities.

Application of EPSDT Criteria for members under the age of 21, are performed at a Physician Reconsideration Review level. Requests for organ transplant services can also be submitted by out-of-state physicians. Procedures may be performed out of the Commonwealth of Virginia only when the authorized transplant cannot be performed within the Commonwealth of Virginia because the service is not available or, due to capacity limitations, the transplant cannot be performed in the necessary time period.

Specific Information for Service Type 0302 Surgical Procedures

Providers must submit requests to KePRO within 14 business days of the need for the surgical procedure and prior to rendering services. KePRO will review completed requests within 3 business days of receipt and make a final determination. KePRO will use the criteria as indicated on the attachment to this memorandum. As of July 1, 2012 there will be no retroactive authorization. This means that if the provider is late submitting the request, KePRO will review the request and make a determination from the date it was received. The only exception will be member retroactive eligibility determination. The days/units that were not submitted timely will be denied and appeal rights provided.

Specific Information for Service Type 0303 Prosthetics

Provider must submit requests to KePRO within 14 business days of the need for prosthetics and all components, and prior to rendering services. As of July 1, 2012 there will be no retroactive authorization. The only exception will be member retroactive eligibility determination. This means that if the provider is late submitting the request, KePRO will review the request and make a determination from the date it was

received. The days/units that were not submitted timely will be denied and appeal rights provided. KePRO will review completed requests within 3 business days of receipt and make a final determination.

Service authorization checklists may be accessed on KePRO's website to assist the provider in assuring specific information is included with each request in order to make a final determination for prosthetics and components. Information from the DMAS 4001 *(Physician's Certification of Need)* may be used to complete the checklist. The service authorization checklists are not mandatory in order to complete the request.

If providers do not wish to use the service authorization checklist, the provider may submit the completed DMAS 4001 *(Physician's Certification of Need)* in its entirety as an attachment to the request when it is submitted.
Since the information from the DMAS 4000 *(Prosthetic Devices Preauthorization Request Form)* has been incorporated into the review process, there is no longer a need for the provider to complete it for the clinical record. The DMAS 4001 *(Physician's Certification of Need)* is still required to be fully completed and present in the clinical record as indicted in the DMAS *Prosthetics Device Manual*, and may be reviewed on post payment or quality management review(s).

Specific Information for Service Type 0304 Medical Device, Services/Maintenance
Provider must submit requests to KePRO within 14 business days of the need and prior to rendering services. As of July 1, 2012 there will be no retroactive authorization. The only exception will be member retroactive eligibility determination. This means that if the provider is late submitting the request, KePRO will review the request and make a determination from the date it was received. The days/units that were not submitted timely will be denied and appeal rights provided. KePRO will review completed requests within 3 business days of receipt and make a final determination.

Specific Information for Out of State Providers
Out of state providers (non-participating, enrolled) are held to the same service authorization processing rules as in state (participating, enrolled) providers and must be enrolled with Virginia Medicaid prior to submitting a request for out of state services to KePRO. If the provider is not enrolled with Virginia Medicaid, the provider is encouraged to submit the request to KePRO, as timeliness of the request will be considered in the review process starting July 1, 2012. KePRO will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled. Providers will not be penalized if DMAS does not process the enrollment request within 12 business days.

If KePRO receives confirmation of the provider's enrollment with Virginia Medicaid within 12 business days, the request will then continue through the review process and a final determination will be made on the service request.

If the request was pended for no provider enrollment and KePRO does not receive confirmation of the provider's enrollment within the 12 business days, KePRO will reject the request back to the provider, as the service authorization cannot be entered into MMIS without the providers National Provider Identification (NPI). Once the provider is successfully enrolled, the provider must resubmit the entire request. Timeliness from the prior submission will not be considered with the re-submission.

Any provider not enrolled with Virginia Medicaid may do so by going to https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment. At the toolbar at the

top of the page, click on "*Provider Services"* and then "*Provider Enrollment"* in the drop down box. It may take up to 10 business days to become a Virginia participating provider.

Review Criteria to be Used

DMAS criteria for medical necessity will be considered if a service is covered under the State Plan and is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve functional disability. Coverage may be denied if the requested service is not medically necessary according to this criteria or is generally regarded by the medical profession as investigational/experimental or not meeting the standard of practice. DMAS criteria includes CMS' Nationally Recognized Criteria (NRC). Therefore, all approvals must meet these agency criteria. All other criteria, including McKesson InterQual®, SIMplus®, or other McKesson review products, CMS, EPSDT, and physician review criteria are used for guidelines and reference purposes only.

McKesson InterQual®: KePRO will apply McKesson InterQual®, SIMplus® criteria or other McKesson product criteria to certain services and DMAS criteria where McKesson InterQual® products do not exist. See attached list for specific criteria.

McKesson SIMplus®: KePRO will apply SIMplus® criteria to those procedure codes identified on the attached spreadsheet. These services will be reviewed retrospectively since SIMplus® is not designed for prospective review of surgeries or for any type of prior authorization. Its use is solely for retrospective review of surgeries. Providers must submit their request timely, within 2 business days, as KePRO will apply timeliness to the review process. If there is additional information required KePRO will pend the request for 20 business days. If the provider does not submit the additional information within the 20 business days specified, then the request will move forward in the review process and a final determination made with the information that has been submitted.

See the attached list of procedure codes at the end of this memo that identifies the criterion to be applied. DMAS criterion is listed in the corresponding DMAS provider manuals and may include CMS' Nationally Recognized Coverage guidelines. DMAS provider manuals are located on the Virginia Medicaid Web Portal, www.virginiamedicaid.dmas.virginia.gov and the KePRO website http://dmas.kepro.com.

Authorizations that Currently Span Past April 1, 2012

Providers that currently have an approved service from DMAS' MSU that is approved past April 1, 2012 need to do nothing. The authorization will be honored and there should be no break in the provider's service. Providers must use the service authorization number issued on their approval letter generated from MMIS for submitting claims. For those providers that received a letter from DMAS' Director of Medical Support or the Director of Program Operations, you will also receive a letter generated by the MMIS by March 31, 2012. If the provider determines that the individual needs a continuance of that approved authorization, the request must be submitted to KePRO prior to the expiration of the initial authorized period. Providers are encouraged to submit the request within 30 days of the expiration date of the current approved time period. KePRO will receive all authorizations that have been performed by DMAS' MSU, both denied and approved, that span past April 1, 2012. If a provider appeals any decision made by DMAS' MSU, DMAS will act upon the appeal through to resolution.

How to Find Out if Procedure Code Requires Service Authorization

In order to determine if services need to be prior authorized, providers should go to the DMAS website: http://dmasva.dmas.virginia.gov and look to the right of the page and click on the section that says

Procedure Fee Files which will then bring you to this: http://www.dmas.virginia.gov/pr-fee_files.htm You will now see a page entitled DMAS Procedure Fee Files. The information provided there will help you determine if a procedure code needs prior authorization or if a procedure code is not covered by DMAS.

To determine if a service needs Prior Authorization, you would then determine whether you wish to use the CSV or the TXT format. The CSV is comma separated value and the TXT is a text format. Depending on the software available on your PC, you may easily use the CSV or the TXT version. The TXT version is recommended for users who wish to download this document into a database application. The CSV Version opens easily in an EXCEL spreadsheet file. Click on either the CSV or the TXT version of the file. Scroll until you find the code you are looking for. The Procedure Fee File will tell you if a code needs to be prior authorized as it will contain a numeric value for the PA Type, such as one of the following:

00 – No PA is required
01 – Always needs a PA
02 – Only needs PA if service limits are exceeded
03 – Always need PA, with per frequency.

To determine whether a service is covered by DMAS you need to access the Procedure Rate File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides you special coverage and/or payment information. A Procedure Flag of "999" indicates that a service is non-covered by DMAS.

Are You Ready for 300H Implementation?

Item #300H of the 2011 General Assembly Appropriation Act requires all providers to submit claims electronically via Electronic Data Interchange (EDI) or Direct Data Entry (DDE), and receive payments via Electronic Funds Transfer (EFT) for those services provided to Medicaid enrollees. If you are not already submitting claims electronically, please contact the EDI Helpdesk at 866-352-0766 for more information. If you do not receive your payment by EFT, please contact Provider Enrollment Services as soon as possible at 888-829-5373. The deadline for all providers to submit their claims electronically and receive payments by EFT is July 1, 2012.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the ACS Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KePRO's Provider Portal, effective October 31, 2011 at http://dmas.kepro.org/.

ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below.

Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com Telephone: 1 (888) 661-5657	SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com Telephone: 1 (610) 219-2322	Emdeon www.emdeon.com Telephone: 1 (877) 363-3666

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

Attachments: DMAS 363, DMAS 351, Prosthetics Checklist, Procedure Code List

Outpatient Service Authorization Request Form
DMAS/KePRO

KePRO/DMAS now requires any Medicaid Provider submitting Service Authorizations using their National Provider Identifier (NPI) or Atypical Provider Identifier (API) to provide their 9 digit zip code. If you do not know your 9 digit zip code then please visit:
http://zip4.usps.com/zip4/welcome.jsp

Submit fax request for Service Authorization to: 1-877–OKBYFAX (877-652-9329)
Requests may be submitted up to 30 days prior to schedule procedures/services, provided Member is eligible.

1. ☐ **Initial** ☐ **Recertification** ☐ **Change** ☐ **Cancel** **Recert: Enter previous SRV AUTH#. Change or Cancel: enter SRV AUTH# to be changed or canceled. SRV AUTH #**

2. **Date of Request (mm/dd/yyyy)** / /	3. **Review Type (check one if applicable)** ☐ Retrospective Prepayment Review (Date notified of eligibility / /) ☐ Retroactive MCO disenrollment			
4. **Member Medicaid ID Number** (12 digit Number):	5. **Member Last Name**:	6. **Member First Name:**	7. **Date of Birth** (mm/dd/yyyy): / /	8. **Gender:** ☐ Male ☐ Female
9. **a. NPI/API/Requesting Service Provider Name & ID Number:** **b. 9 digit Zip Code (Mandatory)**	10. **Treatment Setting** ☐ Outpatient ☐ Provider's Office ☐ Home ☐ Intensive Outpatient	11. **Primary Diagnosis Code/ Description: (enter up to 5)** 1. 2. 3. 4. 5.		
12. **a. NPI/API/Referring Provider Name and ID Number:** **b. 9 digit Zip Code** ***(Mandatory)***	13. **SRV AUTH Service Type:** ☐ 0050 Outpatient Psych ☐ 0092 EPSDT/Orthotics/Chiropractic ☐ 0100 DME ☐ 0204 Outpatient Rehab ☐ 0303 Prosthetics ☐ 0450 MRI ☐ 0451 CAT ☐ 0452 PET ☐ 0500 Home Health			
14. **Severity of Illness (See instructions pertaining to each SRV AUTH service type):**				
15. **Intensity of Services (See instructions pertaining to each SRV AUTH service type):**				
16. **Additional Comments (See instructions pertaining to each SRV AUTH service type):**				

Outpatient Service Authorization Request Form
DMAS/KePRO

Number	17. HCPCS/ CPT/ Revenue Code	18. Code Description	19. Modifiers (if applicable)	20. Units Requested	21. Actual Cost per Unit	22. Frequency	23. Total Dollar Requested	24. Dates of Service	
								From (mm/dd/yyyy)	Thru (mm/dd/yyyy)
1.								/ /	/ /
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18.								/ /	/ /

25. **Contact Name:**

26. **Contact Telephone Number:**

27. **Contact Fax Number:**

Additional Information

14. Severity of Illness:
15. Intensity of Services:
16. Additional Comments:

Outpatient Service Authorization Request Form
DMAS/KePRO

INSTRUCTIONS FOR OUTPATIENT ELECTRONIC FAX FORM

http://dmas.kepro.com
www.dmas.virginia.gov

This FAX submission form is required for faxed outpatient Initial Certification, Recertification, and Retrospective Reviews. When submitting the fax, please be certain that the cover sheet has a confidentiality notice included.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being denied or returned via FAX for additional information. Only information provided on KePRO forms can be entered. Do **not** send attachments or non-KePRO forms.

If KePRO determines that your request meets appropriate coverage criteria guidelines the request will be "tentatively approved" and transmitted to the DMAS Fiscal Agent for the final approval. Final approval is contingent upon passing remaining Member and provider eligibility/enrollment edits. The Service Authorization (SRV AUTH) number provided by the DMAS Fiscal Agent will be sent to you via U.S. mail process and will be available to providers registered on the web-based program Atrezzo Connect (http://dmas.kepro.com) within 24 hours (or the next business day) if reviewed, approved, and transmitted to DMAS' Fiscal Agent prior to 5:30 PM of that day.

1. **Request type:** Place a √ or **X** in the appropriate box.
   - **Initial:** Use for all new requests. Resubmitting a request after receiving a reject would be an initial request also.
   - **Recertification:** A request for continued services (items) beyond the expiration of the previous Service Authorization would be a recertification request.
   - **Change**: a change to a previously approved request; the provider may change the quantity of units, dollar amount approved (DME) or dates of service due to changes in delivery or rescheduling and appointment. If additional units are requested for the same dates of service, enter the total number of units needed and not only the increased amount. Any change request for increased services must include appropriate justification, including information regarding new physician orders. The provider may not submit a "change" request for any item that has been denied or is pended.
   - **Cancel**: Use to cancel all or some of the items under one Service Authorization number. An example of canceling all lines is when an authorization is requested under the wrong Member number.
2. **Date of Request:** The date you are submitting the Service Authorization request.
3. **Review Type:** Place a √ or **X** in the appropriate box. Please refer to the Provider Manuals regarding Retrospective review policy and procedure for detailed information regarding the services being requested. If retrospective eligibility, enter the date that the provider was notified of retrospective eligibility.
4. **Member Medicaid ID Number:** It is the provider's responsibility to ensure the Member's Medicaid number is valid. This should contain 12 numbers.
5. **Member Last Name:** Enter the Member's last name exactly as it appears on the Medicaid card.
6. **Member First Name:** Enter the Member's first name exactly as it appears on the Medicaid card.

7. **Date of Birth**: Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).
8. **Gender:** Please place a √ or **X** to indicate the sex of the member.
9. **a. NPI/API Requesting/Service Provider Name and ID Number:** Enter the requesting/service provider name and ID number, national provider identifier or atypical provider identifier.

   b. 9 digit Zip Code (Mandatory): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI/API number being submitted.
10. **Treatment Setting:** Place a √ or **X** to indicate the place of service. Outpatient Psych: Mark "Outpatient".
11. **Primary Diagnosis Code/Description:** Provide the primary diagnosis code and/or description indicating the reason for service(s). You can enter up to 5 descriptions and ICD-9 codes.
12. **a. NPI/API Referring Provider Name and ID Number:** Enter the referring provider name and ID number, national provider identifier or atypical provider identifier for the provider requesting the service.

    b. 9 digit Zip Code (Mandatory): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI/API number being submitted,
13. **SRV AUTH Service Type:** Place a √ or **X** to indicate the category of service you are requesting. For Chiropractic or Orthotics: If Member is under 21 check "0092 EPSDT/Orthotics/Chiropractic".
14. **Severity of Illness (Clinical indicators of illness including abnormal findings)*:**

    - One of the most important blocks on the form is the Severity of Illness. Knowledge of the InterQual/DMAS criteria will be helpful to provide pertinent information.
    - Provide the clinical information of chief complaint, history of present illness, pertinent past medical history (supportive diagnostic outpatient procedures), abnormal findings on physical examination, previous treatment, pertinent abnormalities in laboratory values, X- rays, and other diagnostic modalities to substantiate the need for service and level of service requested. (Always include dates, types & results [with dimensions/% as appropriate]).
    - Service Type specific instructions:

Outpatient Psych	List all symptoms and behaviors supporting the need for outpatient psychiatric treatment. Clinical documentation should address safety risks (immediate or potential), level of functioning, adequacy of support system and social factors. For continued treatment, include clinical findings within the last five visits and progress towards treatment goals. Clinical updates should describe treatment compliance and any related changes to the individual's psychosocial and medical status.
DME	Provide all of the information listed in Section II of the CMN.
Home Health -Rehab	Describe the functional impairments, illness, injury and/or communication disorders that warrant treatment.
Home Health –Skilled Nursing	Describe specific orders for nursing.

Rehab	Describe the functional impairments, illness, injury and/or communication disorders that warrant treatment.
Prosthetics	Describe the member's functional limitations, device acceptance, psychological/therapeutic value, employment possibility and prosthetic device history. Provide all of the information listed in numbers 15through 17 on the DMAS-4001 (Physician Certification of Need.)
Out of State	Services provided out of state for circumstances other than these specified reasons shall not be covered. 1. The medical services must be needed because of a medical emergency; 2. Medical services must be needed and the Member's health would be endangered if they were required to travel to his/her state of residence; 3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state; 4. It is the general practice for members in a particular locality to use medical resources in another state. See the applicable service type specific instructions above when requesting one of these services.

15. **Intensity of Services (Proposed/Actual monitoring and therapeutic services)*:**

- This is another critical area of the form. Knowledge of the InterQual/DMAS criteria will be helpful to provide pertinent information.
- This field must include the treatment plan for the member. List the services, procedures, or treatments that will be provided to the member.
- Service Type specific instructions:

Outpatient Psych	Identify the treatment modality (i.e. individual, family, or group), number and frequency of sessions and anticipated duration of treatment.
DME	Provide all of the information listed for each line item in Section III and IV of the CMN. Include all items and not only those that require Service Authorization. (If there is no begin service date, list the physician's signature date that is below Section III on pg. 1 and on pg.2 of CMN if applicable.
Home Health	Describe long term and short term goals with achievement dates.
Home Health –Skilled Nursing	Specific description of goals and achievement dates; Specific description of procedures, especially if requesting comprehensive visits; If requesting ongoing comprehensive visits, specify why goals have not been accomplished.
Rehab	Identify if the plan of care is a 60-day plan of care (acute) or an annual plan of care (non-acute); Describe the long term and short term goals with achievement dates; Documentation of meeting program goals.
Prosthetics	Provide all of the information listed in numbers 5through 14 on the DMAS-4001 (Physician Certification of Need.) List the physician's signature date, number 19 on the DMAS-4001.

Out of State	Services provided out of state for circumstances other than these specified reasons shall not be covered. 5. The medical services must be needed because of a medical emergency; 6. Medical services must be needed and the Member's health would be endangered if they were required to travel to his/her state of residence; 7. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state; 8. It is the general practice for members in a particular locality to use medical resources in another state. See the applicable service type specific instructions above when requesting one of these services.

16. **Additional Comments:** This area must be used for further information and other considerations and circumstances to justify your request for medical necessity or the number of services. Describe expected prognosis or functional outcome. List additional information for each item to meet the criteria in the Regulations, DMAS Manual, and InterQual criteria (see SRV AUTH chapter in the DMAS Manuals).

Outpatient Psych	Confirm: psychosocial assessment completed; substance abuse and/or medication evaluations completed (if needed); and plan of care designed, signed, and dated by a Licensed Mental Health Provider (LMHP). Indicate where the service is being provided (Mental Health Clinic, provider's office, home, or nursing home).

17. **HCPCS/CPT/Revenue Code:** Provide the HCPCS/CPT/Revenue procedure code.

NOTE: ***NEW* Starting April 1, 2012, Providers with these Provider Types: 020 (Physician), 023 (Nurse Practitioner), 052 (Federally Qualified Health Center), 053(Rural Health Clinic), or 095 (Out-of-State Physician) can submit request(s) for Outpatient Rehab services utilizing any of the following Revenue Codes:**

- **0420: Physical Therapy (P.T.)-General – 1 Unit = 1 Visit**
- **0430: Occupational Therapy (O.T.)-General – 1 Unit = 1 Visit**
- **0440: Speech Language Pathology-General – 1 Unit = 1 Visit**

NOTE: Providers please reference the Medicaid Memos for OP Rehab providers: 5/27/09, 6/29/10 and new 3/2012 Memo (refers to 4/1/12 change) at this link: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/MedicaidMemostoProviders

REMINDER FOR ALL OP REHAB PROVIDERS: All Outpatient Rehab service authorization (Srv Auth) requests will end on or prior to June 30th of each year. On July 1st of each year, the 5 service limits/units per discipline for Rehab agencies, CORFs, physicians, professionals and the 5 service limits/visits per discipline for Hospitals is renewed in order to allow for the utilization of the 5 units/visits that do not require Srv Auth. If a provider knows that the member will need

treatment beyond 5 visits, they must request Srv Auth through KePRO. The Srv Auth request will start with the first date after the 5 units or visits have been utilized.

18. **Code Description:** Provide the HCPCS/CPT/Revenue procedure code description. For NEOP, provide the type of scan and location.
19. **Modifiers (if applicable):** Enter up to 4 modifiers as applicable. DME providers enter modifier as appropriate based upon the Durable Medical Equipment and Supplies Listing/Appendix B found in the DMAS DME provider manual information.
20. **Units Requested**: Based on physician's orders, plan of care, or CMN provide the number of services/visits requested. Knowledge of InterQual/DMAS criteria will be extremely helpful. DME providers: Only identify the number of units' necessary in excess of the established allowable for the time span requested. Place numbers only in the Units Requested block. Units requested as 2/2 months or 100/box/month or 7 days cannot be keyed and will be rejected.
21. **Actual Cost per Unit or Usual and Customary (DME providers only)**: Enter information in this column for codes identified in Appendix B as individual consideration (IC) or usual and customary. For IC, enter actual cost per unit less any incentives/discounts or reductions received from the manufacturer. For items identified in Appendix B as usual and customary, enter the provider's usual and customary charge to the generic public. The provider must retain documentation supporting this dollar amount. (**Prosthetic providers only)** for codes identified as individual consideration (IC), enter actual cost per unit less any incentives/discounts or reduction received from the manufacturer. The provider must retain documentation supporting this dollar amount.
22. **Frequency:** Enter Frequency usage of Service requested
23. **Total Dollars Requested (DME providers only)**: Enter the dollar amount requested for items listed as usual and customary or IC in the appendix B of the DMAS DME provider manual. In the Appendix B, each code is listed with a set fee, as usual and customary or IC. The Total Dollars Requested is the total for all units requested in that line. For items listed as usual and customary enter your usual and customary charge to the general public. For items listed as IC enter the dollar amount requested. The provider must retain documentation supporting verification of cost (a manufacturer's invoice, brochure with cost information from the manufacturer, cost estimate on letterhead from the manufacturer, etc.) This cost is per unit of the item being requested, e.g. 1ea, 1 pair, or 1 box of 100. **(Prosthetic providers only)** enter the same dollar amount requested in number 21.
24. **Dates of Service**: Indicate the planned service dates using the mm/dd/yyyy format. The From and Thru date must be completed even if they are the same date.
25. **Contact Name**: Enter the name of the person to contact if there are any questions regarding this fax form.
26. **Contact Telephone Number:** Enter the phone number with area code of the contact name.
27. **Contact Fax Number:** Enter the fax number with the area code to respond if there is a denial/reject.

***Note: Incomplete data may result in the request being denied; therefore, it is very important that this field be completed as thoroughly as possible with the pertinent medical/clinical information. The purpose of Service Authorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Service Authorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the Member's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.**

Procedures/Devices Service Authorization Request Form
Virginia Department of Medical Assistance Services

KePRO/DMAS now requires any Medicaid Provider submitting Service Authorizations using their National Provider Identifier (NPI) or Atypical Provider Identifier (API) to provide their 9 digit zip code. If you do not know your 9 digit zip code then please visit: http://zip4.usps.com/zip4/welcome.jsp

Submit fax request for Service Authorization to: 1-877–OKBYFAX (877-652-9329)
Requests may be submitted up to 30 days prior to schedule procedures/services, provided Member is eligible.

1. ☐ Original ☐ **Cancel** ☐ **Change** **Recert: Enter previous SRV AUTH#. Change or Cancel: enter SRV AUTH# to be changed or canceled. SRV AUTH #**

2. **Date of Request (mm/dd/yyyy)** / /	3. **Review Type (check one if applicable)** ☐ Retrospective Prepayment Review (Date notified of eligibility / /) ☐ Retroactive MCO disenrollment			
4. **Member Medicaid ID Number** (12 digit Number):	5. **Member Last Name**:	6. **Member First Name:**	7. **Date of Birth** (mm/dd/yyyy): / /	8. **Gender:** ☐ Male ☐ Female
9. **a**. **NPI/API/Requesting Service Provider Name & ID Number:** **b**. **9 digit Zip Code (Mandatory)**	10. **Treatment Setting** ☐ Outpatient ☐ Home ☐ Outpatient Hospital ☐ Nursing Home ☐ Outpatient Clinic ☐ Ambulatory Surgical Ctr. ☐ Intensive Outpatient ☐ Provider's Office		11. **Primary Diagnosis Code/ Description: (enter up to 5)** 1. 2. 3. 4. 5.	
12. **a**. **NPI/API/Referring Provider Name and ID Number:** **b**. **9 digit Zip Code** ***(Mandatory)***	13. **SRV AUTH Service Type:** ☐ 0300 Organ Transplant ☐ 0302 Surgical Procedures ☐ 0304 Medical Device/Service			
14. **Severity of Illness (See instructions pertaining to each SRV AUTH service type):**				
15. **Intensity of Services (See instructions pertaining to each SRV AUTH service type):**				
16. **Additional Comments (See instructions pertaining to each SRV AUTH service type):**				

Procedures/Devices Service Authorization Request Form
Virginia Department of Medical Assistance Services

Number	17. HCPCS/ CPT Code	18. Code Description	19. Modifiers (if applicable)	20. Units Requested	21. Actual Cost per Unit	22. Frequency	23. Total Dollar Requested	24. Dates of Service	
								From (mm/dd/yyyy)	Thru (mm/dd/yyyy)
1.								/ /	/ /
2.								/ /	/ /
3.								/ /	/ /
4.								/ /	/ /
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16.								/ /	/ /
17.								/ /	/ /
18.								/ /	/ /

25. **Contact Name:**

26. **Contact Telephone Number:**

27. **Contact Fax Number:**

14. Severity of Illness:
15. Intensity of Services:
16. Additional Comments:

Procedures/Devices Service Authorization Request Form
Virginia Department of Medical Assistance Services

INSTRUCTIONS FOR OUTPATIENT ELECTRONIC FAX FORM

http://dmas.kepro.com
www.dmas.virginia.gov

This FAX submission form is required for faxed outpatient Initial Certification, Recertification, and Retrospective Reviews. When submitting the fax, please be certain that the cover sheet has a confidentiality notice included.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being denied or returned via FAX for additional information. Only information provided on KePRO forms can be entered. Do **not** send attachments or non-KePRO forms.

If KePRO determines that your request meets appropriate coverage criteria guidelines the request will be "tentatively approved" and transmitted to the DMAS Fiscal Agent for the final approval. Final approval is contingent upon passing remaining Member and provider eligibility/enrollment edits. The Service Authorization (SRV AUTH) number provided by the DMAS Fiscal Agent will be sent to you via U.S. mail process and will be available to providers registered on the web-based program Atrezzo Connect (http://dmas.kepro.com) within 24 hours (or the next business day) if reviewed, approved, and transmitted to DMAS' Fiscal Agent prior to 5:30 PM of that day.

1. **Request type:** Place a √ or **X** in the appropriate box.
   - **Initial:** Use for all new requests. Resubmitting a request after receiving a reject would be an initial request also.
   - **Recertification:** A request for continued services (items) beyond the expiration of the previous Service Authorization would be a recertification request.
   - **Change**: a change to a previously approved request; the provider may change the quantity of units, dollar amount approved (DME) or dates of service due to changes in delivery or rescheduling and appointment. If additional units are requested for the same dates of service, enter the total number of units needed and not only the increased amount. Any change request for increased services must include appropriate justification, including information regarding new physician orders. The provider may not submit a "change" request for any item that has been denied or is pended.
   - **Cancel**: Use to cancel all or some of the items under one Service Authorization number. An example of canceling all lines is when an authorization is requested under the wrong Member number.
2. **Date of Request:** The date you are submitting the Service Authorization request.
3. **Review Type:** Place a √ or **X** in the appropriate box. Please refer to the Provider Manuals regarding Retrospective review policy and procedure for detailed information regarding the services being requested. If retrospective eligibility, enter the date that the provider was notified of retrospective eligibility.
4. **Member Medicaid ID Number:** It is the provider's responsibility to ensure the Member's Medicaid number is valid. This should contain 12 numbers.

5. **Member Last Name:** Enter the Member's last name exactly as it appears on the Medicaid card.
6. **Member First Name:** Enter the Member's first name exactly as it appears on the Medicaid card.
7. **Date of Birth**: Date of birth is critically important and should be in the format of mm/dd/yyyy (for example, 02/25/2004).
8. **Gender:** Please place a √ or **X** to indicate the sex of the member.
9. **a. NPI/API Requesting/Service Provider Name and ID Number:** Enter the requesting/service provider name and ID number, national provider identifier or atypical provider identifier.

   b. 9 digit Zip Code (Mandatory): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI/API number being submitted.
10. **Treatment Setting:** Place a √ or **X** to indicate the place of service. Outpatient Psych: Mark "Outpatient".
11. **Primary Diagnosis Code/Description:** Provide the primary diagnosis code and/or description indicating the reason for service(s). You can enter up to 5 descriptions and ICD-9 codes.
12. **a. NPI/API Referring Provider Name and ID Number:** Enter the referring provider name and ID number, national provider identifier or atypical provider identifier for the provider requesting the service.

    b. 9-digit Zip Code (Mandatory): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI/API number being submitted,
13. **SRV AUTH Service Type:** Place a √ or **X** to indicate the category of service you are requesting. Orthotics: If Member is under 21 check "Orthotics (EPSDT)".
14. **Severity of Illness (Clinical indicators of illness including abnormal findings)*:**

    - One of the most important blocks on the form is the Severity of Illness. Knowledge of the InterQual/DMAS criteria will be helpful to provide pertinent information.
    - Provide the clinical information of chief complaint, history of present illness, pertinent past medical history (supportive diagnostic outpatient procedures), abnormal findings on physical examination, previous treatment, pertinent abnormalities in laboratory values, X- rays, and other diagnostic modalities to substantiate the need for service and level of service requested. (Always include dates, types & results [with dimensions/% as appropriate]).
    - Service Type specific instructions:

Procedures/Devices Service Authorization Request Form
Virginia Department of Medical Assistance Services

Organ Transplant	Pre-Transplant evaluations. Full Vital Signs (Temperature, BP, P, RR, and Pulse Oximetry on Room Air) Abnormal Diagnostic Studies: Labs, Imaging, EKG Results, Medications and/or IV fluids ordered. Prior Outpatient Treatment Including Medications Prescribed in Last 72 Hours, Functional and/or Cognitive Impairments. **Please Describe Any Other Pertinent Information Related to this Service Authorization Request**
Surgical Procedures	Surgical Procedure being requested. Reason for the surgery. Include any Pertinent Medical History. Full Vital Signs (Temperature, BP, P, RR, Pulse Oximetry on Room Air) Abnormal Diagnostic Studies: Labs, Imaging, EKG Results. Prior Outpatient Treatment Including Medications Prescribed in Last 72 Hours, Medications and/or IV fluids ordered. **Please Describe Any Other Pertinent Information Related to this Service Authorization Request**
Medical Device/Services/Maintenance	Provide all of the information listed for each line item in Section III and IV of the CMN. Include all items and not only those that require Service Authorization. If there is no begin service date, list the physician's signature date that is below Section III on pg. 1 and on pg.2 of CMN if applicable. Date of Injury/Illness/Surgery causing need for this service. Level of Need ie. Acute or Chronic, Long/Short Term Goals, Rental or Purchase. Describe what level of assistance is required for each impairment. List specialized equipment the member requires. List Therapeutic Interventions (Medications, Nutrition and/or Adaptive devices Etc.). List Mobility, Endurance, and any Activity impairments **Please Describe Any Other Pertinent Information Related to this Service Authorization Request**

Out of State	Services provided out of state for circumstances other than these specified reasons shall not be covered. 1. The medical services must be needed because of a medical emergency; 2. Medical services must be needed and the member's health would be endangered if they were required to travel to his/her state of residence; 3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state; 4. It is the general practice for members in a particular locality to use medical resources in another state. See the applicable service type specific instructions above when requesting one of these services.

15. **Intensity of Services (Proposed/Actual monitoring and therapeutic services)*:**
    - This is another critical area of the form. Knowledge of the InterQual/DMAS criteria will be helpful to provide pertinent information.
    - This field must include the treatment plan for the member. List the services, procedures, or treatments that will be provided to the member.
    - Service Type specific instructions:

16. **Additional Comments:** This area must be used for further information and other considerations and circumstances to justify your request for medical necessity or the number of services. Describe expected prognosis or functional outcome. List additional information for each item to meet the criteria in the Regulations, DMAS Manual, and InterQual criteria (see SRV AUTH chapter in the DMAS Manuals).

17. **HCPCS/CPT Code: Provide the HCPCS/CPT procedure code.**

18. **Code Description:** Provide the HCPCS/CPT/procedure code description.

19. **Modifiers (if applicable):** Enter up to 4 modifiers as applicable. DME providers enter modifier as appropriate based upon the Durable Medical Equipment and Supplies Listing/Appendix B found in the DMAS DME provider manual information.

Procedures/Devices Service Authorization Request Form
Virginia Department of Medical Assistance Services

20. **Units Requested**: Based on physician's orders, plan of care, or CMN provide the number of services/visits requested. Knowledge of InterQual/DMAS criteria will be extremely helpful. DME providers: Only identify the number of units' necessary in excess of the established allowable for the time span requested. Place numbers only in the Units Requested block. Units requested as 2/2 months or 100/box/month or 7 days cannot be keyed and will be rejected.
21. **Frequency:** Enter Frequency usage of Service requested
22. **Dates of Service**: Indicate the planned service dates using the mm/dd/yyyy format. The From and Thru date must be completed even if they are the same date.
23. **Contact Name**: Enter the name of the person to contact if there are any questions regarding this fax form.
24. **Contact Telephone Number:** Enter the phone number with area code of the contact name.
25. **Contact Fax Number:** Enter the fax number with the area code to respond if there is a denial/reject.

***Note: Incomplete data may result in the request being denied; therefore, it is very important that this field be completed as thoroughly as possible with the pertinent medical/clinical information.**

The purpose of Service Authorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Service Authorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the Member's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.

Prosthetic Device Service Authorization Information Checklist

Service Type: 0303
Provide Physician Signature Date on CMN (DMAS 4001): / / (mm/dd/yyyy)
Provider Contact Name and Phone Number: Telephone - -
Is this a Retro Review: ☐ Yes ☐ No

1. Diagnosis:
2. Member's Height and Weight: Height Feet Inches Weight Pounds
3. Date and Reason for Original Amputation: / / (mm/dd/yyyy). Reason:
4. Describe Member's Functional Limitations:
5. Enter a comment regarding acceptance of the device by the member.
6. Enter psychological and /or therapeutic value expected for the member.
7. Enter Employment possibility.
8. Enter Prosthetic Device History.
9. Are other amputations anticipated within the next twelve months? ☐ Yes ☐ No. If Yes, please explain:
10. If this member has undergone a lower extremity amputation, please include the date the member last ambulated: / / (mm/dd/yyyy)
11. List any current significant medical conditions and their present treatments, e.g. arthritis, vascular disease, neuropathy, diabetes.
12. Is the member's cognitive and physical status sufficient to enable learning the use of prosthesis? ☐ Yes ☐ No
13. If the member has had a prosthetic limb, why does it need to be replaced or repaired?
14. Additional medical justification needed for special prosthetic components, e.g. lightweight equipment, special terminal devices, modified sockets, modified feet, etc.
15. Indicate strength testing of all extremities, including range of motion across all joints, including the contralateral limb:
16. Are there any signs on examination consistent with vascular disease in the contralateral limb? Document the present condition and viability of the contralateral limb.
17. Are there any conditions that would preclude or delay the use of prosthesis, i. e., edema, open wound, contractures or poor skin viability? ☐ Yes ☐ No
18. List Actual Cost for prosthesis and/or special prosthetic components: $

Code	Procedure Description	Service Type	Review Criteria
11401*	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS, LEGS; EXCISED DIAMETER 0.6 TO 1.0 CM	0302	McKesson InterQual® SIMplus
11402*	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS, LEGS; EXCISED DIAMETER 1.0 TO 2.0 CM	0302	McKesson InterQual® SIMplus
11403*	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS, LEGS; EXCISED DIAMETER 2.1 TO 3.0 CM	0302	McKesson InterQual® SIMplus
11404*	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS, LEGS; EXCISED DIAMETER 3.1 TO 4.0 CM	0302	McKesson InterQual® SIMplus
11406*	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS, LEGS; EXCISED DIAMETER OVER 4.0 CM	0302	McKesson InterQual® SIMplus
11421*	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE),SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 0.6 TO 1.0 CM	0302	McKesson InterQual® SIMplus
11422*	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE),SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 1.1 TO 2.0 CM	0302	McKesson InterQual® SIMplus
11423*	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE),SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 2.1 TO 3.0 CM	0302	McKesson InterQual® SIMplus
11424*	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE),SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 3.1 TO 4.0 CM	0302	McKesson InterQual® SIMplus

11426*	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE),SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER OVER 4.0 CM	0302	McKesson InterQual® SIMplus
11441*	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE),FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER 0.6 TO 1.0 CM	0302	McKesson InterQual® SIMplus
11442*	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE),FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER 1.1 TO 2.0 CM	0302	McKesson InterQual® SIMplus
11443*	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE),FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER 2.1 TO 3.0 CM	0302	McKesson InterQual® SIMplus
11444*	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE),FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER 3.1 TO 4.0 CM	0302	McKesson InterQual® SIMplus
11446*	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE),FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER OVER 4.0 CM	0302	McKesson InterQual® SIMplus
11900*	INJECTION, INTRALESIONAL; UP TO AND INCLUDING 7 LESIONS	0302	DMAS Criteria/DMAS Provider Manual
11901*	INJECTION, INTRALESIONAL; MORE THAN 7 LESIONS	0302	DMAS Criteria/DMAS Provider Manual
21245*	RECONSTRUCTION OF MANDIBLE OR MAXILLA, SUBPERIOSTEAL IMPLANT; COMPLETE	0302	McKesson InterQual® Care Planning; Procedures Adult
21246*	RECONSTRUCTION OF MANDIBLE OR MAXILLA, SUBPERIOSTEAL IMPLANT; PARTIAL	0302	McKesson InterQual® Care Planning; Procedures Adult
21247*	RECONSTRUCTION OF MANDIBULAR CONDYLE WITH BONE AND CARTILAGE AUTOGRAFTS (INCLUDING OBTAINING GRAFTS) (EG, FOR HEMIFACIAL MICROSOMIA	0302	DMAS Criteria/DMAS Provider Manual

21248*	RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT (EG, BLADE, CYLINDER); PARTIAL	0302	DMAS Criteria/DMAS Provider Manual
21249*	RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT (EG, BLADE, CYLINDER); COMPLETE	0302	DMAS Criteria/DMAS Provider Manual
21275*	SECONDARY REVISION OF ORBITOCRANIOFACIAL RECONSTRUCTION	0302	DMAS Criteria/DMAS Provider Manual
28344*	RECONSTRUCTION, TOE(S); POLYDACTYLY	0302	DMAS Criteria/DMAS Provider Manual
28345*	RECONSTRUCTION, TOE(S); SYNDACTYLY, WITH OR WITHOUT SKIN GRAFT(S), EACH WEB	0302	DMAS Criteria/DMAS Provider Manual
28360*	RECONSTRUCTION, CLEFT FOOT	0302	DMAS Criteria/DMAS Provider Manual
30462*	RHINOPLASTY FOR NASAL DEFORMITY SECONDARY TO CONGENITAL CLEFT LIP AND.OR PALATE, INCLUDING COLUMELLAR LENGTHENING; TIP, SEPTUM, OSTEOTOMIES	0302	DMAS Criteria/DMAS Provider Manual
40700*	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; PRIMARY, PARTIAL OR COMPLETE, UNILATERAL	0302	McKesson InterQual® Care Planning; Procedures Pediatric and SIMplus
40701*	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; PRIMARY BILATERAL, 1 STAGE-PROCEDURE	0302	McKesson InterQual® Care Planning; Procedures Pediatric and SIMplus
40702*	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; PRIMARY BILATERAL, 1OF 2 STAGES	0302	McKesson InterQual® Care Planning; Procedures Pediatric and SIMplus
40720*	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; SECONDARY, BY RECREATION OF DEFECT AND RECLOSURE	0302	DMAS Criteria/DMAS Provider Manual
44135	INTESTINAL ALLOTRANSPLANTATION; FROM CADAVER DONOR	0300	DMAS Criteria/DMAS Provider Manual
44136*	INTESTINAL ALLOTRANSPLANTATION; FROM LIVING DONOR	0300	DMAS Criteria/DMAS Provider Manual
61867*	TWIST DRILL, BURR HOLE, CRANIOTOMY, OR CRANIECTOMY WITH STEREOTACTIC IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY IN SUBCORTICAL SITE (EG, THALAMUS, GLOBUS PALLIDUS, SUBTHALAMIC NUCLEUS, PERIVENTRICULAR, PERIAQUEDUTAL GRAY), WITH USE OF INTRAOPERATIVE MICROELECTRODE RECORDING; FIRST ARRAY	0302	McKesson InterQual® Care Planning; Procedures Adult

61868*	TWIST DRILL, BURR HOLE, CRANIOTOMY, OR CRANIECTOMY WITH STEREOTACTIC IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY IN SUBCORTICAL SITE (EG, THALAMUS, GLOBUS PALLIDUS, SUBTHALAMIC NUCLEUS, PERIVENTRICULAR, PERIAQUEDUTAL GRAY), WITH USE OF INTRAOPERATIVE MICROELECTRODE RECORDING;EACH ADDITIONAL ARRAY	0302	McKesson InterQual® Care Planning; Procedures Adult
61888*	REVISION OR REMOVAL OF CRANIAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER	0302	DMAS Criteria/DMAS Provider Manual
62351	IMPLANTATION, REVISION OR REPOSITIONING OF TUNNELED INTRATHECAL OR EPIDURAL CATHETER, FOR LONG TERM MEDICATION ADMINISTRATION VIA AN EXTERNAL PUMP OR IMPLANTABLE RESERVOIR/INFUSION PUMP; WITH LAMINECTOMY	0302	DMAS Criteria/DMAS Provider Manual
63663*	REVISION INCLUDING REPLACEMENT, WHEN PERFORMED, OF SPINAL NEUROSTIMULATOR ELECTRODE PERCUTANEOUS ARRAY(S), INCLUDING FLUOROSCOPY, WHEN PERFORMED	0302	McKesson InterQual® Care Planning; Procedures Adult
63664*	REVISION INCLUDING REPLACEMENT, WHEN PERFORMED, OF SPINAL NEUROSTIMULATOR ELECTRODE PLATE/PADDLE(S) PLACED VIA LAMINOTOMY OR LAMINECTOMY, INCLUDING FLUOROSCOPY, WHEN PERFORMED	0302	DMAS Criteria/DMAS Provider Manual
63685*	INSERTION OR REPLACEMENT OF SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING	0302	McKesson InterQual® Care Planning; Procedures Adult
63688*	REVISION OR REMOVAL OF IMPLANTED SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER	0302	DMAS Criteria/DMAS Provider Manual
67921*	REPAIR OF ENTOPION; SUTURE	0302	McKesson InterQual® Care Planning; Procedures Adult
67922*	REPAIR OF ENTOPION; THERMOCAUTERIZATION	0302	McKesson InterQual® Care Planning; Procedures Adult
67923*	REPAIR OF ENTOPION; EXCISION OF TARSAL WEDGE	0302	McKesson InterQual® Care Planning; Procedures Adult
0019T	EXRACORPOREAL SHOCK WAVE INVOLVING MUSCULOSKELETAL SYSTEM NOS LOW ENERGY	0302	DMAS Criteria/DMAS Provider Manual
0078T	ENDOVASCULAR REPAIR OF ABDOMINAL AORTIC ANEURYSM, PSEUDOANEURYSM OR DISSECTION,	0302	DMAS Criteria/DMAS Provider Manual
0079T	PLACEMENT OF VISCERAL EXTENSION PROSTHESIS FOR ENDOVASCULAR REPAIR OF ABDOMINAL	0302	DMAS Criteria/DMAS Provider Manual

0080T	ENDOVASCULAR REPAIR OF ABDOMINAL AORTIC ANEURYSM, PSEUDOANEURYSM OR DISSECTION,	0302	DMAS Criteria/DMAS Provider Manual
0099T	IMPLANTATION OF INTRASTROMAL CORNEAL RING SEGMENTS	0302	DMAS Criteria/DMAS Provider Manual
10040	ACNE SURGERY (EG, MARSUPIALIZATION, OPENING OR REMOVAL OF MULTIPLE MILIA,	0302	DMAS Criteria/DMAS Provider Manual
11200	REMOVAL OF SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY AREA; UP TO AND IN	0302	DMAS Criteria/DMAS Provider Manual
11201	REMOVAL OF SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY AREA; EACH ADDITIO	0302	DMAS Criteria/DMAS Provider Manual
11400	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED	0302	McKesson InterQual® SIMplus
11420	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED	0302	McKesson InterQual® SIMplus
11440	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS (UNLESS LISTED ELSEWHERE),	0302	McKesson InterQual® SIMplus
11920	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORREC	0302	DMAS Criteria/DMAS Provider Manual
11921	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORREC	0302	DMAS Criteria/DMAS Provider Manual
11960	INSERTION OF TISSUE EXPANDER(S) FOR OTHER THAN BREAST, INCLUDING SUBSEQUEN	0302	DMAS Criteria/DMAS Provider Manual
11970	REPLACEMENT OF TISSUE EXPANDER WITH PERMANENT PROSTHESIS	0302	DMAS Criteria/DMAS Provider Manual
14060	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, NOSE, EARS AND/OR LIPS	0302	McKesson InterQual® Care Planning; Procedures Adult
14061	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, NOSE, EARS AND/OR LIPS	0302	McKesson InterQual® Care Planning; Procedures Adult
15820	BLEPHAROPLASTY, LOWER EYELID;	0302	DMAS Criteria/DMAS Provider Manual
15821	BLEPHAROPLASTY, LOWER EYELID; WITH EXTENSIVE HERNIATED FAT PAD	0302	DMAS Criteria/DMAS Provider Manual
15822	BLEPHAROPLASTY, UPPER EYELID;	0302	McKesson InterQual® Care Planning; Procedures Adult
15823	BLEPHAROPLASTY, UPPER EYELID; WITH EXCESSIVE SKIN WEIGHTING DOWN LID	0302	McKesson InterQual® Care Planning; Procedures Adult
15824	RHYTIDECTOMY; FOREHEAD	0302	DMAS Criteria/DMAS Provider Manual
15825	RHYTIDECTOMY; NECK WITH PLATYSMAL TIGHTENING (PLATYSMAL FLAP, P-FLAP)	0302	DMAS Criteria/DMAS Provider Manual
15826	RHYTIDECTOMY; GLABELLAR FROWN LINES	0302	DMAS Criteria/DMAS Provider Manual
15828	RHYTIDECTOMY; CHEEK, CHIN, AND NECK	0302	DMAS Criteria/DMAS Provider Manual

15829	RHYTIDECTOMY; SUPERFICIAL MUSCULOAPONEUROTIC SYSTEM (SMAS) FLAP	0302	DMAS Criteria/DMAS Provider Manual
15830	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ABDOMEN,	0302	McKesson InterQual® Care Planning; Procedures Adult
15831	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); AB	0302	McKesson InterQual® Care Planning; Procedures Adult
15832	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); TH	0302	DMAS Criteria/DMAS Provider Manual
15833	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); LE	0302	DMAS Criteria/DMAS Provider Manual
15834	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); HI	0302	DMAS Criteria/DMAS Provider Manual
15835	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); BU	0302	DMAS Criteria/DMAS Provider Manual
15836	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); AR	0302	DMAS Criteria/DMAS Provider Manual
15837	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); FO	0302	DMAS Criteria/DMAS Provider Manual
15838	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); SU	0302	DMAS Criteria/DMAS Provider Manual
15839	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); OT	0302	DMAS Criteria/DMAS Provider Manual
15847	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY), ABDOMEN	0302	DMAS Criteria/DMAS Provider Manual
15876	SUCTION ASSISTED LIPECTOMY; HEAD AND NECK	0302	McKesson InterQual® Care Planning; Procedures Adult
15877	SUCTION ASSISTED LIPECTOMY; TRUNK	0302	McKesson InterQual® Care Planning; Procedures Adult
17106	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQ	0302	DMAS Criteria/DMAS Provider Manual
17107	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQ	0302	DMAS Criteria/DMAS Provider Manual
17108	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQ	0302	DMAS Criteria/DMAS Provider Manual
17380	ELECTROLYSIS EPILATION, EACH 1/2 HOUR	0302	DMAS Criteria/DMAS Provider Manual
19300	MASTECTOMY	0302	McKesson InterQual® Care Planning; Procedures Adult
19316	MASTOPEXY	0302	DMAS Criteria/DMAS Provider Manual
19318	REDUCTION MAMMAPLASTY	0302	McKesson InterQual® Care Planning; Procedures Adult
19324	MAMMAPLASTY, AUGMENTATION; WITHOUT PROSTHETIC IMPLANT	0302	McKesson InterQual® Care Planning; Procedures Adult

19325	MAMMAPLASTY, AUGMENTATION; WITH PROSTHETIC IMPLANT	0302	McKesson InterQual® Care Planning; Procedures Adult
19328	REMOVAL OF INTACT MAMMARY IMPLANT	0302	McKesson InterQual® Care Planning; Procedures Adult
19330	REMOVAL OF MAMMARY IMPLANT MATERIAL	0302	McKesson InterQual® Care Planning; Procedures Adult
19340	IMMEDIATE INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTOMY O	0302	McKesson InterQual® Care Planning; Procedures Adult
19342	DELAYED INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTOMY OR	0302	McKesson InterQual® Care Planning; Procedures Adult
19350	NIPPLE/AREOLA RECONSTRUCTION	0302	DMAS Criteria/DMAS Provider Manual
19355	CORRECTION OF INVERTED NIPPLES	0302	DMAS Criteria/DMAS Provider Manual
19357	BREAST RECONSTRUCTION, IMMEDIATE OR DELAYED, WITH TISSUE EXPANDER, INCLUDI	0302	McKesson InterQual® Care Planning; Procedures Adult
19361	BREAST RECONSTRUCTION WITH LATISSIMUS DORSI FLAP, WITH OR WITHOUT PROSTHET	0302	McKesson InterQual® Care Planning; Procedures Adult
19364	BREAST RECONSTRUCTION WITH FREE FLAP	0302	McKesson InterQual® Care Planning; Procedures Adult
19366	BREAST RECONSTRUCTION WITH OTHER TECHNIQUE	0302	McKesson InterQual® Care Planning; Procedures Adult
19367	BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP	0302	McKesson InterQual® Care Planning; Procedures Adult
19368	BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP	0302	McKesson InterQual® Care Planning; Procedures Adult
19369	BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP	0302	McKesson InterQual® Care Planning; Procedures Adult
19380	REVISION OF RECONSTRUCTED BREAST	0302	DMAS Criteria/DMAS Provider Manual
19396	PREPARATION OF MOULAGE FOR CUSTOM BREAST IMPLANT	0302	DMAS Criteria/DMAS Provider Manual
20974	ELECTRICAL STIMULATION TO AID BONE HEALING; NONINVASIVE (NONOPERATIVE)	0302	DMAS Criteria/DMAS Provider Manual
20975	ELECTRICAL STIMULATION TO AID BONE HEALING; INVASIVE (OPERATIVE)	0302	McKesson InterQual® Care Planning; Procedures Adult
20979	LOW INTENSITY ULTRASOUND STIMULATION TO AID BONE HEALING, NONINVASIVE (NON	0302	DMAS Criteria/DMAS Provider Manual
21073	MANIPULATION OF TEMPOROMANDIBULAR JOINT(S) (TMJ), THERAPEUTIC, REQUIRING AN	0302	DMAS Criteria/DMAS Provider Manual
21076	IMPRESSION AND CUSTOM PREPARATION; SURGICAL OBTURATOR PROSTHESIS	0302	DMAS Criteria/DMAS Provider Manual
21077	IMPRESSION AND CUSTOM PREPARATION; ORBITAL PROSTHESIS	0302	DMAS Criteria/DMAS Provider Manual

21079	IMPRESSION AND CUSTOM PREPARATION; INTERIM OBTURATOR PROSTHESIS	0302	DMAS Criteria/DMAS Provider Manual
21080	IMPRESSION AND CUSTOM PREPARATION; DEFINITIVE OBTURATOR PROSTHESIS	0302	DMAS Criteria/DMAS Provider Manual
21081	IMPRESSION AND CUSTOM PREPARATION; MANDIBULAR RESECTION PROSTHESIS	0302	DMAS Criteria/DMAS Provider Manual
21082	IMPRESSION AND CUSTOM PREPARATION; PALATAL AUGMENTATION PROSTHESIS	0302	DMAS Criteria/DMAS Provider Manual
21083	IMPRESSION AND CUSTOM PREPARATION; PALATAL LIFT PROSTHESIS	0302	DMAS Criteria/DMAS Provider Manual
21084	IMPRESSION AND CUSTOM PREPARATION; SPEECH AID PROSTHESIS	0302	DMAS Criteria/DMAS Provider Manual
21085	IMPRESSION AND CUSTOM PREPARATION; ORAL SURGICAL SPLINT	0302	DMAS Criteria/DMAS Provider Manual
21086	IMPRESSION AND CUSTOM PREPARATION; AURICULAR PROSTHESIS	0302	DMAS Criteria/DMAS Provider Manual
21088	IMPRESSION AND CUSTOM PREPARATION; FACIAL PROSTHESIS	0302	DMAS Criteria/DMAS Provider Manual
21089	UNLISTED MAXILLOFACIAL PROSTHETIC PROCEDURE	0302	DMAS Criteria/DMAS Provider Manual
21120*	**GENIOPLASTY; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, PROSTHETIC MATERIAL)**	0302	DMAS Criteria/DMAS Provider Manual
21121	GENIOPLASTY; SLIDING OSTEOTOMY, SINGLE PIECE	0302	DMAS Criteria/DMAS Provider Manual
21122	GENIOPLASTY; SLIDING OSTEOTOMIES, TWO OR MORE OSTEOTOMIES (EG, WEDGE EXCIS	0302	DMAS Criteria/DMAS Provider Manual
21123	GENIOPLASTY; SLIDING, AUGMENTATION WITH INTERPOSITIONAL BONE GRAFTS (INCLU	0302	DMAS Criteria/DMAS Provider Manual
21125	AUGMENTATION, MANDIBULAR BODY OR ANGLE; PROSTHETIC MATERIAL	0302	McKesson InterQual® SIMplus
21127	AUGMENTATION, MANDIBULAR BODY OR ANGLE; WITH BONE GRAFT, ONLAY OR INTERPOS	0302	McKesson InterQual® SIMplus
21141	RECONSTRUCTION MIDFACE, LEFORT I; SINGLE PIECE, SEGMENT MOVEMENT IN ANY DI	0302	McKesson InterQual® Care Planning; Procedures Adult
21142	RECONSTRUCTION MIDFACE, LEFORT I; TWO PIECES, SEGMENT MOVEMENT IN ANY DIRE	0302	McKesson InterQual® Care Planning; Procedures Adult
21143	RECONSTRUCTION MIDFACE, LEFORT I; THREE OR MORE PIECES, SEGMENT MOVEMENT I	0302	McKesson InterQual® Care Planning; Procedures Adult
21145	RECONSTRUCTION MIDFACE, LEFORT I; SINGLE PIECE, SEGMENT MOVEMENT IN ANY DI	0302	McKesson InterQual® Care Planning; Procedures Adult

21146	RECONSTRUCTION MIDFACE, LEFORT I; TWO PIECES, SEGMENT MOVEMENT IN ANY DIRE	0302	McKesson InterQual® Care Planning; Procedures Adult
21147	RECONSTRUCTION MIDFACE, LEFORT I; THREE OR MORE PIECES, SEGMENT MOVEMENT I	0302	McKesson InterQual® Care Planning; Procedures Adult
21150	RECONSTRUCTION MIDFACE, LEFORT II; ANTERIOR INTRUSION (EG, TREACHER-COLLIN	0302	DMAS Criteria/DMAS Provider Manual
21151	RECONSTRUCTION MIDFACE, LEFORT II; ANY DIRECTION, REQUIRING BONE GRAFTS (I	0302	DMAS Criteria/DMAS Provider Manual
21154	RECONSTRUCTION MIDFACE, LEFORT III (EXTRACRANIAL), ANY TYPE, REQUIRING BON	0302	DMAS Criteria/DMAS Provider Manual
21155	RECONSTRUCTION MIDFACE, LEFORT III (EXTRACRANIAL), ANY TYPE, REQUIRING BON	0302	DMAS Criteria/DMAS Provider Manual
21159	RECONSTRUCTION MIDFACE, LEFORT III (EXTRA AND INTRACRANIAL) WITH FOREHEAD	0302	DMAS Criteria/DMAS Provider Manual
21160	RECONSTRUCTION MIDFACE, LEFORT III (EXTRA AND INTRACRANIAL) WITH FOREHEAD	0302	DMAS Criteria/DMAS Provider Manual
21172	RECONSTRUCTION SUPERIOR-LATERAL ORBITAL RIM AND LOWER FOREHEAD, ADVANCEMEN	0302	DMAS Criteria/DMAS Provider Manual
21175	RECONSTRUCTION, BIFRONTAL, SUPERIOR-LATERAL ORBITAL RIMS AND LOWER FOREHEA	0302	DMAS Criteria/DMAS Provider Manual
21179*	**RECONSTRUCTION, ENTIRE OR MAJORITY OF FOREHEAD AND/OR SUPRAORBITAL RIMS; W**	0302	DMAS Criteria/DMAS Provider Manual
21180*	**RECONSTRUCTION, ENTIRE OR MAJORITY OF FOREHEAD AND/OR SUPRAORBITAL RIMS; W**	0302	DMAS Criteria/DMAS Provider Manual
21193	RECONSTRUCTION OF MANDIBULAR RAMI, HORIZONTAL, VERTICAL, C, OR L OSTEOTOMY	0302	McKesson InterQual® Care Planning; Procedures Adult
21194	RECONSTRUCTION OF MANDIBULAR RAMI, HORIZONTAL, VERTICAL, C, OR L OSTEOTOMY	0302	McKesson InterQual® Care Planning; Procedures Adult
21195	RECONSTRUCTION OF MANDIBULAR RAMI AND/OR BODY, SAGITTAL SPLIT; WITHOUT INT	0302	McKesson InterQual® Care Planning; Procedures Adult
21196	RECONSTRUCTION OF MANDIBULAR RAMI AND/OR BODY, SAGITTAL SPLIT; WITH INTERN	0302	McKesson InterQual® Care Planning; Procedures Adult
21198	OSTEOTOMY, MANDIBLE, SEGMENTAL;	0302	McKesson InterQual® Care Planning; Procedures Adult
21199	OSTEOTOMY, MANDIBLE, SEGMENTAL; WITH GENIOGLOSSUS ADVANCEMENT	0302	McKesson InterQual® Care Planning; Procedures Adult
21206	OSTEOTOMY, MAXILLA, SEGMENTAL (EG, WASSMUND OR SCHUCHARD)	0302	McKesson InterQual® Care Planning; Procedures Adult
21240	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH OR WITHOUT AUTOGRAFT (INCLUDES	0302	McKesson InterQual® Care Planning; Procedures Adult

21242	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH ALLOGRAFT	0302	McKesson InterQual® Care Planning; Procedures Adult
21243	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH PROSTHETIC JOINT REPLACEMENT	0302	McKesson InterQual® Care Planning; Procedures Adult
21270	MALAR AUGMENTATION, PROSTHETIC MATERIAL	0302	DMAS Criteria/DMAS Provider Manual
21282	LATERAL CANTHOPEXY	0302	DMAS Criteria/DMAS Provider Manual
22856	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING	0302	DMAS Criteria/DMAS Provider Manual
30140	SUBMUCOUS RESECTION TURBINATE, PARTIAL OR COMPLETE, ANY METHOD	0302	McKesson InterQual® Care Planning; Procedures Adult
30220	INSERTION, NASAL SEPTAL PROSTHESIS (BUTTON)	0302	DMAS Criteria/DMAS Provider Manual
30400	RHINOPLASTY, PRIMARY; LATERAL AND ALAR CARTILAGES AND/OR ELEVATION OF NASA	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
30410	RHINOPLASTY, PRIMARY; COMPLETE, EXTERNAL PARTS INCLUDING BONY PYRAMID, LAT	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
30420	RHINOPLASTY, PRIMARY; INCLUDING MAJOR SEPTAL REPAIR	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
30430	RHINOPLASTY, SECONDARY; MINOR REVISION (SMALL AMOUNT OF NASAL TIP WORK)	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
30435	RHINOPLASTY, SECONDARY; INTERMEDIATE REVISION (BONY WORK WITH OSTEOTOMIES)	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
30450	RHINOPLASTY, SECONDARY; MAJOR REVISION (NASAL TIP WORK AND OSTEOTOMIES)	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
30460	RHINOPLASTY FOR NASAL DEFORMITY SECONDARY TO CONGENITAL CLEFT LIP AND/OR	0302	DMAS Criteria/DMAS Provider Manual
30520	SEPTOPLASTY OR SUBMUCOUS RESECTION, WITH OR WITHOUT CARTILAGE SCORING, CON	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
32553	PLACEMENT OF INTERSTITIAL DEVICE(S) FOR RADIATION THERAPY GUIDANCE (EG,	0302	DMAS Criteria/DMAS Provider Manual
32851*	**LUNG TRANSPLANT, SINGLE; WITHOUT CARDIOPULMONARY BYPASS**	0300	DMAS Criteria/DMAS Provider Manual
32852*	**LUNG TRANSPLANT, SINGLE; WITH CARDIOPULMONARY BYPASS**	0300	DMAS Criteria/DMAS Provider Manual
32853*	**LUNG TRANSPLANT, DOUBLE (BILATERAL SEQUENTIAL OR EN BLOC); WITHOUT CARDIOP**	0300	DMAS Criteria/DMAS Provider Manual
32854*	**LUNG TRANSPLANT, DOUBLE (BILATERAL SEQUENTIAL OR EN BLOC); WITH CARDIOPULM**	0300	DMAS Criteria/DMAS Provider Manual
33935*	**HEART-LUNG TRANSPLANT WITH RECIPIENT CARDIECTOMY-PNEUMONECTOMY**	0300	McKesson InterQual® Cardiac Transplant

33945*	**HEART TRANSPLANT, WITH OR WITHOUT RECIPIENT CARDIECTOMY**	0300	McKesson InterQual® Cardiac Transplant
33970	INSERTION OF INTRA-AORTIC BALLOON ASSIST DEVICE THROUGH THE FEMORAL ARTERY	0302	McKesson InterQual® SIMplus 2008
33973	INSERTION OF INTRA-AORTIC BALLOON ASSIST DEVICE THROUGH THE ASCENDING AORT	0302	McKesson InterQual® SIMplus 2008
33975	INSERTION OF VENTRICULAR ASSIST DEVICE; EXTRACORPOREAL, SINGLE VENTRICLE	0302	DMAS Criteria/DMAS Provider Manual
33976	INSERTION OF VENTRICULAR ASSIST DEVICE; EXTRACORPOREAL, BIVENTRICULAR	0302	DMAS Criteria/DMAS Provider Manual
33979	INSERTION OF VENTRICULAR ASSIST DEVICE, IMPLANTABLE INTRACORPOREAL, SINGLE	0302	DMAS Criteria/DMAS Provider Manual
33982	REPLACEMENT OF VENTRICULAR ASSIST DEVICE PUMP(S); IMPLANTABLE INTRACORPOREAL,	0302	DMAS Criteria/DMAS Provider Manual
36470*	**INJECTION OF SCLEROSING SOLUTION; SINGLE VEIN**	0302	McKesson InterQual® Care Planning; Procedures Adult
36471*	**INJECTION OF SCLEROSING SOLUTION; MULTIPLE VEINS, SAME LEG**	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
36475	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
36476	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL	0302	McKesson InterQual® SIMplus
36478	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
36479	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL	0302	McKesson InterQual® SIMplus
36511	THERAPEUTIC APHERESIS; FOR WHITE BLOOD CELLS	0302	DMAS Criteria/DMAS Provider Manual
38240*	**BONE MARROW OR BLOOD-DERIVED PERIPHERAL STEM CELL TRANSPLANTATION; ALLOGEN**	0300	McKesson InterQual® Care Planning; Procedures Adult
38241*	**BONE MARROW OR BLOOD-DERIVED PERIPHERAL STEM CELL TRANSPLANTATION; AUTOLOG**	0300	McKesson InterQual® Care Planning; Procedures Adult
41820	GINGIVECTOMY, EXCISION GINGIVA, EACH QUADRANT	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus 2008
41821	OPERCULECTOMY, EXCISION PERICORONAL TISSUES	0302	DMAS Criteria/DMAS Provider Manual
41828	EXCISION OF HYPERPLASTIC ALVEOLAR MUCOSA, EACH QUADRANT (SPECIFY)	0302	DMAS Criteria/DMAS Provider Manual
41830	ALVEOLECTOMY, INCLUDING CURETTAGE OF OSTEITIS OR SEQUESTRECTOMY	0302	DMAS Criteria/DMAS Provider Manual
41870	PERIODONTAL MUCOSAL GRAFTING	0302	DMAS Criteria/DMAS Provider Manual
41872	GINGIVOPLASTY, EACH QUADRANT (SPECIFY)	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus 2008

41874	ALVEOLOPLASTY, EACH QUADRANT (SPECIFY)	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus 2008
42145	PALATOPHARYNGOPLASTY (EG, UVULOPALATOPHARYNGOPLASTY, UVULOPHARYNGOPLASTY)	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
42280	MAXILLARY IMPRESSION FOR PALATAL PROSTHESIS	0302	DMAS Criteria/DMAS Provider Manual
43644	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; WITH GASTRIC BYPASS AND	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
43645	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; WITH GASTRIC BYPASS AND	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
43770	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; PLACEMENT OF ADJUSTABLE	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
43771	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REVISION OF ADJUSTABLE	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus 2010
43772	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL OF ADJUSTABLE	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus 2010
43773	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL AND REPLACEMENT	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus 2010
43774	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL OF ADJUSTABLE	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus 2010
43775	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; LONGITUDINAL GASTRECTOMY	0302	DMAS Criteria/DMAS Provider Manual
43842	GASTRIC RESTRICTIVE PROCEDURE, WITHOUT GASTRIC BYPASS, FOR MORBID OBESITY;	0302	McKesson InterQual® Care Planning; Procedures Adult 2010 and SIMplus 2009
43843	GASTRIC RESTRICTIVE PROCEDURE, WITHOUT GASTRIC BYPASS, FOR MORBID OBESITY;	0302	McKesson InterQual® Care Planning; Procedures Adult 2010 and SIMplus 2009
43845	GASTRIC RESTRICTIVE PROCEDURE W/ PARTIAL GASTRECTOMY	0302	McKesson InterQual® Care Planning; Procedures Adult 2010 and SIMplus 2009
43846	GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRIC BYPASS FOR MORBID OBESITY; WIT	0302	McKesson InterQual® Care Planning; Procedures Adult 2010 and SIMplus 2009
43847	GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRIC BYPASS FOR MORBID OBESITY; WIT	0302	McKesson InterQual® Care Planning; Procedures Adult 2010 and SIMplus 2009
43848	REVISION OF GASTRIC RESTRICTIVE PROCEDURE FOR MORBID OBESITY (SEPARATE PRO	0302	DMAS Criteria/DMAS Provider Manual
43886	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REVISION OF SUBCUTANEOUS PORT COMPONENT	0302	DMAS Criteria/DMAS Provider Manual
43887	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REMOVAL OF SUBCUTANEOUS PORT COMPONENT ONLY	0302	DMAS Criteria/DMAS Provider Manual
43888	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REMOVAL AND REPLACEMENT OF SUBCUTANEOUS	0302	DMAS Criteria/DMAS Provider Manual

46750	SPHINCTEROPLASTY, ANAL, FOR INCONTINENCE OR PROLAPSE; ADULT	0302	DMAS Criteria/DMAS Provider Manual
46751	SPHINCTEROPLASTY, ANAL, FOR INCONTINENCE OR PROLAPSE; CHILD	0302	DMAS Criteria/DMAS Provider Manual
47135*	**LIVER ALLOTRANSPLANTATION; ORTHOTOPIC, PARTIAL OR WHOLE, FROM CADAVER OR L**	0300	McKesson InterQual® Care Planning; Procedures Adult
47136*	**LIVER ALLOTRANSPLANTATION; HETEROTOPIC, PARTIAL OR WHOLE, FROM CADAVER OR**	0300	DMAS Criteria/DMAS Provider Manual
48160	PANCREATECTOMY, TOTAL OR SUBTOTAL, WITH AUTOLOGOUS TRANSPLANTATION OF PANC	0300	DMAS Criteria/DMAS Provider Manual
48554*	**TRANSPLANTATION OF PANCREATIC ALLOGRAFT**	0300	DMAS Criteria/DMAS Provider Manual
49411	PLACEMENT OF INTERSTITIAL DEVICE(S) FOR RADIATION THERAPY GUIDANCE (EG,	0302	DMAS Criteria/DMAS Provider Manual
50360	RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; EXCLUDING DONOR AND RECI	0300	McKesson InterQual® Care Planning; Procedures Adult
50365	RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; WITH RECIPIENT NEPHRECTO	0300	McKesson InterQual® Care Planning; Procedures Adult
50380	RENAL AUTOTRANSPLANTATION, REIMPLANTATION OF KIDNEY	0300	DMAS Criteria/DMAS Provider Manual
53445	INSERTION OF INFLATABLE URETHRAL/BLADDER NECK SPHINCTER, INCLUDING PLACEME	0302	DMAS Criteria/DMAS Provider Manual
53447	REMOVAL AND REPLACEMENT OF INFLATABLE URETHRAL/BLADDER NECK SPHINCTER INCL	0302	DMAS Criteria/DMAS Provider Manual
53449	REPAIR OF INFLATABLE URETHRAL/BLADDER NECK SPHINCTER, INCLUDING PUMP, RESE	0302	DMAS Criteria/DMAS Provider Manual
54400	INSERTION OF PENILE PROSTHESIS; NON-INFLATABLE (SEMI-RIGID)	0302	McKesson InterQual® Care Planning; Procedures Adult
54401	INSERTION OF PENILE PROSTHESIS; INFLATABLE (SELF-CONTAINED)	0302	McKesson InterQual® Care Planning; Procedures Adult
54405	INSERTION OF MULTI-COMPONENT, INFLATABLE PENILE PROSTHESIS, INCLUDING PLAC	0302	McKesson InterQual® Care Planning; Procedures Adult
54406	REMOVAL OF ALL COMPONENTS OF A MULTI-COMPONENT, INFLATABLE PENILE PROSTHES	0302	DMAS Criteria/DMAS Provider Manual
54408	REPAIR OF COMPONENT(S) OF A MULTI-COMPONENT, INFLATABLE PENILE PROSTHESIS	0302	DMAS Criteria/DMAS Provider Manual
54410	REMOVAL AND REPLACEMENT OF ALL COMPONENT(S) OF A MULTI-COMPONENT, INFLATAB	0302	DMAS Criteria/DMAS Provider Manual
54415	REMOVAL OF NON-INFLATABLE (SEMI-RIGID) OR INFLATABLE (SELF-CONTAINED) PENI	0302	DMAS Criteria/DMAS Provider Manual

54416	REMOVAL AND REPLACEMENT OF NON-INFLATABLE (SEMI-RIGID) OR INFLATABLE (SELF	0302	DMAS Criteria/DMAS Provider Manual
55175	SCROTOPLASTY; SIMPLE	0302	DMAS Criteria/DMAS Provider Manual
55180	SCROTOPLASTY; COMPLICATED	0302	DMAS Criteria/DMAS Provider Manual
57426	REVISION (INCLUDING REMOVAL) OF PROSTHETIC VAGINAL GRAFT, LAPAROSCOPIC APPROACH	0302	DMAS Criteria/DMAS Provider Manual
60512	PARATHYROID AUTOTRANSPLANTATION (LIST SEPARATELY IN ADDITION TO CODE FOR	0302	DMAS Criteria/DMAS Provider Manual
61793	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY OR LINEAR ACCELERATOR)	0302	McKesson InterQual® Care Planning; Procedures Adult
61796	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); 1	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
61797	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY, OR LINEAR ACCELERATOR);	0302	DMAS Criteria/DMAS Provider Manual
61798	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); 1	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
61799	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY, OR LINEAR ACCELERATOR);	0302	DMAS Criteria/DMAS Provider Manual
61800	APPLICATION OF STEREOTACTIC HEADFRAME FOR STEREOTACTIC RADIOSURGERY (LIST	0302	DMAS Criteria/DMAS Provider Manual
61885*	**INCISION AND SUBCUTANEOUS PLACEMENT OF CRANIAL NEUROSTIMULATOR PULSE GENER**	0302	McKesson InterQual® Care Planning; Procedures Adult
61886*	**INCISION AND SUBCUTANEOUS PLACEMENT OF CRANIAL NEUROSTIMULATOR PULSE GENER**	0302	McKesson InterQual® Care Planning; Procedures Adult
62350*	**IMPLANTATION, REVISION OR REPOSITIONING OF TUNNELED INTRATHECAL OR EPIDURA**	0302	McKesson InterQual® Care Planning; Procedures Adult
62355	REMOVAL OF PREVIOUSLY IMPLANTED INTRATHECAL OR EPIDURAL CATHETER	0302	DMAS Criteria/DMAS Provider Manual
62360	IMPLANTATION OR REPLACEMENT OF DEVICE FOR INTRATHECAL OR EPIDURAL DRUG INF	0302	McKesson InterQual® Care Planning; Procedures Adult and SIMplus
62361	IMPLANTATION OR REPLACEMENT OF DEVICE FOR INTRATHECAL OR EPIDURAL DRUG INF	0302	DMAS Criteria/DMAS Provider Manual
62362	IMPLANTATION OR REPLACEMENT OF DEVICE FOR INTRATHECAL OR EPIDURAL DRUG INF	0302	DMAS Criteria/DMAS Provider Manual
63620	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); 1	0302	DMAS Criteria/DMAS Provider Manual
63621	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY, OR LINEAR ACCELERATOR);	0302	DMAS Criteria/DMAS Provider Manual

63650	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY, EPIDURAL	0302	McKesson InterQual® Care Planning; Procedures Adult
64553	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; CRANIAL NERVE	0302	DMAS Criteria/DMAS Provider Manual
64555	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; PERIPHERAL NERVE	0302	DMAS Criteria/DMAS Provider Manual
64560	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; AUTONOMIC NERVE	0302	DMAS Criteria/DMAS Provider Manual
64561	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; SACRAL NERVE (TRA	0302	DMAS Criteria/DMAS Provider Manual
64565	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; NEUROMUSCULAR	0302	DMAS Criteria/DMAS Provider Manual
64566*	**POSTERIOR TIBIAL NEUROSTIMULATION, PERCUTANEOUS NEEDLE ELECTRODE, SINGLE**	0302	DMAS Criteria/DMAS Provider Manual
64568	INCISION FOR IMPLANTATION OF CRANIAL NERVE (EG, VAGUS NERVE) NEUROSTIMULATOR	0302	McKesson InterQual® Care Planning; Procedures Adult
64569*	**REVISION OR REPLACEMENT OF CRANIAL NERVE (EG, VAGUS NERVE) NEUROSTIMULATOR**	0302	DMAS Criteria/DMAS Provider Manual
64570*	**REMOVAL OF CRANIAL NERVE (EG, VAGUS NERVE) NEUROSTIMULATOR ELECTRODE ARRAY AND**	0302	DMAS Criteria/DMAS Provider Manual
64575	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; PERIPHERAL NERVE	0302	DMAS Criteria/DMAS Provider Manual
64577	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; AUTONOMIC NERVE	0302	DMAS Criteria/DMAS Provider Manual
64580	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; NEUROMUSCULAR	0302	DMAS Criteria/DMAS Provider Manual
64581	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; SACRAL NERVE (TRA	0302	DMAS Criteria/DMAS Provider Manual
64585	REVISION OR REMOVAL OF PERIPHERAL NEUROSTIMULATOR ELECTRODES	0302	DMAS Criteria/DMAS Provider Manual
64590	INCISION AND SUBCUTANEOUS PLACEMENT OF PERIPHERAL NEUROSTIMULATOR PULSE GE	0302	McKesson InterQual® Care Planning; Procedures Adult
64595	REVISION OR REMOVAL OF PERIPHERAL NEUROSTIMULATOR PULSE GENERATOR OR RECEI	0302	McKesson InterQual® Care Planning; Procedures Adult
65780	OCULAR SURFACE RECONSTRUCTION; AMNIOTIC MEMBRANE TRANSPLANTATION	0302	DMAS Criteria/DMAS Provider Manual
67900	REPAIR OF BROW PTOSIS (SUPRACILIARY, MID-FOREHEAD OR CORONAL APPROACH)	0302	DMAS Criteria/DMAS Provider Manual

67901	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH SUTURE OR OTHER	0302	McKesson InterQual® Care Planning; Procedures Adult
67902	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH FASCIAL SLING (I	0302	McKesson InterQual® Care Planning; Procedures Adult
67903	REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR ADVANCEMENT, INTERN	0302	McKesson InterQual® Care Planning; Procedures Adult
67904	REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR ADVANCEMENT, EXTERN	0302	McKesson InterQual® Care Planning; Procedures Adult
67906	REPAIR OF BLEPHAROPTOSIS; SUPERIOR RECTUS TECHNIQUE WITH FASCIAL SLING (IN	0302	McKesson InterQual® Care Planning; Procedures Adult
67908	REPAIR OF BLEPHAROPTOSIS; CONJUNCTIVO-TARSO-MULLER'S MUSCLE-LEVATOR RESECT	0302	McKesson InterQual® Care Planning; Procedures Adult
67909	REDUCTION OF OVERCORRECTION OF PTOSIS	0302	DMAS Criteria/DMAS Provider Manual
67911	CORRECTION OF LID RETRACTION	0302	DMAS Criteria/DMAS Provider Manual
67914*	**REPAIR OF ECTROPION; SUTURE**	0302	McKesson InterQual® Care Planning; Procedures Adult
67915*	**REPAIR OF ECTROPION; THERMOCAUTERIZATION**	0302	McKesson InterQual® Care Planning; Procedures Adult
67917*	**REPAIR OF ECTROPION; BLEPHAROPLASTY, EXTENSIVE (EG, KUHNT-SZYMANOWSKI OR T**	0302	McKesson InterQual® Care Planning; Procedures Adult
69300	OTOPLASTY, PROTRUDING EAR, WITH OR WITHOUT SIZE REDUCTION	0302	DMAS Criteria/DMAS Provider Manual
69710	IMPLANTATION OR REPLACEMENT OF ELECTROMAGNETIC BONE CONDUCTION HEARING DEV	0302	DMAS Criteria/DMAS Provider Manual
69711	REMOVAL OR REPAIR OF ELECTROMAGNETIC BONE CONDUCTION HEARING DEVICE IN TEM	0302	DMAS Criteria/DMAS Provider Manual
69714	IMPLANTATION, OSSEOINTEGRATED IMPLANT, TEMPORAL BONE, WITH PERCUTANEOUS AT	0302	DMAS Criteria/DMAS Provider Manual
69715	IMPLANTATION, OSSEOINTEGRATED IMPLANT, TEMPORAL BONE, WITH PERCUTANEOUS AT	0302	DMAS Criteria/DMAS Provider Manual
69717	REPLACEMENT (INCLUDING REMOVAL OF EXISTING DEVICE), OSSEOINTEGRATED IMPLAN	0302	DMAS Criteria/DMAS Provider Manual
69718	REPLACEMENT (INCLUDING REMOVAL OF EXISTING DEVICE), OSSEOINTEGRATED IMPLAN	0302	DMAS Criteria/DMAS Provider Manual
69930	COCHLEAR DEVICE IMPLANTATION, WITH OR WITHOUT MASTOIDECTOMY	0302	McKesson InterQual® Care Planner; Procedures Adult and Pediatric
77520	PROTON TREATMENT DELIVERY; SIMPLE, WITHOUT COMPENSATION	0302	DMAS Criteria/DMAS Provider Manual
77522	PROTON TREATMENT DELIVERY; SIMPLE, WITH COMPENSATION	0302	DMAS Criteria/DMAS Provider Manual

77523	PROTON TREATMENT DELIVERY; INTERMEDIATE	0302	DMAS Criteria/DMAS Provider Manual
77525	PROTON TREATMENT DELIVERY; COMPLEX	0302	DMAS Criteria/DMAS Provider Manual
82107	ALPHA-FETOPROTEIN (AFP); AFP-L3 FRACTION ISOFORM AND TOTAL AFP (INCLUDING RATIO)	0302	DMAS Criteria/DMAS Provider Manual
90284	IMMUNE GLOBULIN (SCIG), HUMAN, FOR USE IN SUBCUTANEOUS INFUSIONS, 100 MG, EACH	0302	DMAS Criteria/DMAS Provider Manual
90889	PREPARATION OF REPORT OF PATIENT'S PSYCHIATRIC STATUS, HISTORY, TREATMENT,	0302	DMAS Criteria/DMAS Provider Manual
91110	GASTROINTESTINAL TRACT IMAGING, INTRALUMINAL (EG, CAPSULE ENDOSCOPY), ESOPHAGUS	0302	McKesson InterQual® Imaging
92310	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF AND FITTING OF CON	0304	DMAS Criteria/DMAS Provider Manual
92311	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF AND FITTING OF CON	0304	DMAS Criteria/DMAS Provider Manual
92312	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF AND FITTING OF CON	0304	DMAS Criteria/DMAS Provider Manual
92313	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF AND FITTING OF CON	0304	DMAS Criteria/DMAS Provider Manual
92314	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF CONTACT LENS, WITH	0304	DMAS Criteria/DMAS Provider Manual
92315	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF CONTACT LENS, WITH	0304	DMAS Criteria/DMAS Provider Manual
92316	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF CONTACT LENS, WITH	0304	DMAS Criteria/DMAS Provider Manual
92317	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF CONTACT LENS, WITH	0304	DMAS Criteria/DMAS Provider Manual
92640	DIAGNOSTIC ANALYSIS WITH PROGRAMMING OF AUDITORY BRAINSTEM IMPLANT, PER HOUR	0302	DMAS Criteria/DMAS Provider Manual
94777	PEDIATRIC HOME APNEA MONITORING EVENT RECORDING INCLUDING RESPIRATORY RATE,	0302	DMAS Criteria/DMAS Provider Manual
95921	TESTING OF AUTONOMIC NERVOUS SYSTEM FUNCTION; CARDIOVAGAL INNERVATION (PAR	0302	DMAS Criteria/DMAS Provider Manual
95922	TESTING OF AUTONOMIC NERVOUS SYSTEM FUNCTION; VASOMOTOR ADRENERGIC INNERVA	0302	DMAS Criteria/DMAS Provider Manual
95923	TESTING OF AUTONOMIC NERVOUS SYSTEM FUNCTION; SUDOMOTOR, INCLUDING ONE OR	0302	DMAS Criteria/DMAS Provider Manual
95978	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM (EG,	0302	DMAS Criteria/DMAS Provider Manual

95979*	**ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM (EG,**	0302	DMAS Criteria/DMAS Provider Manual
96020	NEUROFUNCTIONAL TESTING SELECTION AND ADMINISTRATION DURING NONINVASIVE IMAGING	0302	DMAS Criteria/DMAS Provider Manual
96900	ACTINOTHERAPY (ULTRAVIOLET LIGHT)	0302	DMAS Criteria/DMAS Provider Manual
97605	NEGATIVE PRESSURE WOUND THERAPY (EG, VACUUM ASSISTED DRAINAGE COLLECTION),	0302	DMAS Criteria/DMAS Provider Manual
97606	NEGATIVE PRESSURE WOUND THERAPY (EG, VACUUM ASSISTED DRAINAGE COLLECTION),	0302	DMAS Criteria/DMAS Provider Manual
98940	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, ONE TO TWO REGIONS	0092	McKesson InterQual® Rehab and Chiropractic
98941*	**CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, THREE TO FOUR REGIONS**	0092	McKesson InterQual® Rehab and Chiropractic
98942	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, FIVE REGIONS	0092	McKesson InterQual® Rehab and Chiropractic
98943	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); EXTRASPINAL, ONE OR MORE REGION	0092	McKesson InterQual® Rehab and Chiropractic
99183	PHYSICIAN ATTENDANCE AND SUPERVISION OF HYPERBARIC OXYGEN THERAPY, PER SES	0302	DMAS Criteria/DMAS Provider Manual
A8002	HELMET, PROTECTIVE, SOFT, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND	0304	McKesson InterQual® DME 2010
A8003	HELMET, PROTECTIVE, HARD, CUSTOM FABRICATED, INCLUDES ALL COMPONENTS AND	0304	McKesson InterQual® DME 2010
A8004	SOFT INTERFACE FOR HELMET, REPLACEMENT ONLY	0304	DMAS Criteria/DMAS Provider Manual
A9155	ARTIFICIAL SALIVA, 30 ML	0304	DMAS Criteria/DMAS Provider Manual
A9276	SENSOR; INVASIVE (E.G. SUBCUTANEOUS), DISPOSABLE, FOR USE WITH INTERSTITIAL	0304	DMAS Criteria/DMAS Provider Manual
C1300	HYPERBARIC OXYGEN UNDER PRESSURE, FULL BODY CHAMBER, PER 30 MINUTE INTERVA	0304	DMAS Criteria/DMAS Provider Manual
E0747*	**OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, OTHER THAN SPINAL APPLI**	0304	McKesson InterQual® DME
E0748*	**OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, SPINAL APPLICATIONS**	0304	McKesson InterQual® DME
E0749*	**OSTEOGENESIS STIMULATOR, ELECTRICAL, SURGICALLY IMPLANTED**	0304	DMAS Criteria/DMAS Provider Manual
J1725	Injection, Hydroxyprogesterone caproate (Makena)	0302	DMAS Criteria/DMAS Provider Manual
E0760*	**OSTOGENESIS STIMULATOR, LOW INTENSITY ULTRASOUND, NON-INVASIVE**	0304	McKesson InterQual® DME
J2278	INJECTION, ZICONOTIDE, 1 MICROGRAM	0302	DMAS Criteria/DMAS Provider Manual

J2323	INJECTION, NATALIZUMAB, 1 MG	0302	DMAS Criteria/DMAS Provider Manual
J2796	INJECTION, ROMIPLOSTIM, 10 MICROGRAMS	0302	DMAS Criteria/DMAS Provider Manual
K0606*	**AUTOMATIC EXTERNAL DEFIBRILLAR, WITH INTEGRATED ELECTROCARDIOGRAM ANALYSIS, GARMENT TYPE**	0304	McKesson InterQual® DME
L5000	PARTIAL FOOT, SHOE INSERT WITH LONGITUDINAL ARCH, TOE FILLER	0303	DMAS Criteria/DMAS Provider Manual
L5010	PARTIAL FOOT, MOLDED SOCKET, ANKLE HEIGHT, WITH TOE FILLER	0303	DMAS Criteria/DMAS Provider Manual
L5020	PARTIAL FOOT, MOLDED SOCKET, TIBIAL TUBERCLE HEIGHT, WITH TOE FILLER	0303	DMAS Criteria/DMAS Provider Manual
L5050	ANKLE, SYMES, MOLDED SOCKET, SACH FOOT	0303	DMAS Criteria/DMAS Provider Manual
L5060	ANKLE, SYMES, METAL FRAME, MOLDED LEATHER SOCKET, ARTICULATED ANKLE/FOOT	0303	DMAS Criteria/DMAS Provider Manual
L5100	BELOW KNEE, MOLDED SOCKET, SHIN, SACH FOOT	0303	McKesson InterQual® Care Planning; DME
L5105	BELOW KNEE, PLASTIC SOCKET, JOINTS AND THIGH LACER, SACH FOOT	0303	McKesson InterQual® Care Planning; DME
L5150	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, EXTERNAL KNEE JOINT	0303	McKesson InterQual® Care Planning; DME
L5160	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, BENT KNEE CONFIGURA	0303	McKesson InterQual® Care Planning; DME
L5200	ABOVE KNEE, MOLDED SOCKET, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH	0303	McKesson InterQual® Care Planning; DME
L5210	ABOVE KNEE, SHORT PROSTHESIS, NO KNEE JOINT ('STUBBIES'), WITH FOOT BLOCKS	0303	DMAS Criteria/DMAS Provider Manual
L5220	ABOVE KNEE, SHORT PROSTHESIS, NO KNEE JOINT ('STUBBIES'), WITH ARTICULATED	0303	DMAS Criteria/DMAS Provider Manual
L5230	ABOVE KNEE, FOR PROXIMAL FEMORAL FOCAL DEFICIENCY, CONSTANT FRICTION KNEE,	0303	DMAS Criteria/DMAS Provider Manual
L5250	HIP DISARTICULATION, CANADIAN TYPE; MOLDED SOCKET, HIP JOINT, SINGLE AXIS	0303	DMAS Criteria/DMAS Provider Manual
L5270	HIP DISARTICULATION, TILT TABLE TYPE; MOLDED SOCKET, LOCKING HIP JOINT, SI	0303	DMAS Criteria/DMAS Provider Manual
L5280	HEMIPELVECTOMY, CANADIAN TYPE; MOLDED SOCKET, HIP JOINT, SINGLE AXIS CONST	0303	DMAS Criteria/DMAS Provider Manual
L5301	BELOW KNEE, MOLDED SOCKET, SHIN, SACH FOOT, ENDOSKELETAL SYSTEM	0303	McKesson InterQual® Care Planning; DME
L5311	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, EXTERNAL KNEE JOINT	0303	McKesson InterQual® Care Planning; DME

L5321	ABOVE KNEE, MOLDED SOCKET, OPEN END, SACH FOOT, ENDOSKELETAL SYSTEM, SINGL	0303	McKesson InterQual® Care Planning; DME
L5331	HIP DISARTICULATION, CANADIAN TYPE, MOLDED SOCKET, ENDOSKELETAL SYSTEM, H	0303	DMAS Criteria/DMAS Provider Manual
L5341	HEMIPELVECTOMY, CANADIAN TYPE, MOLDED SOCKET, ENDOSKELETAL SYSTEM, HIP JOI	0303	DMAS Criteria/DMAS Provider Manual
L5400	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRE	0303	McKesson InterQual® Care Planning; DME
L5410	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRE	0303	McKesson InterQual® Care Planning; DME
L5420	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRE	0303	McKesson InterQual® Care Planning; DME
L5430	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRE	0303	McKesson InterQual® Care Planning; DME
L5450	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF NON-WEIGHT BEARIN	0303	DMAS Criteria/DMAS Provider Manual
L5460	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF NON-WEIGHT BEARIN	0303	DMAS Criteria/DMAS Provider Manual
L5500	INITIAL, BELOW KNEE 'PTB' TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COV	0303	McKesson InterQual® Care Planning; DME
L5505	INITIAL, ABOVE KNEE - KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, NON-ALIG	0303	McKesson InterQual® Care Planning; DME
L5510	PREPARATORY, BELOW KNEE 'PTB' TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON,	0303	McKesson InterQual® Care Planning; DME
L5520	PREPARATORY, BELOW KNEE 'PTB' TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO	0303	McKesson InterQual® Care Planning; DME
L5530	PREPARATORY, BELOW KNEE 'PTB' TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO	0303	McKesson InterQual® Care Planning; DME
L5535	PREPARATORY, BELOW KNEE 'PTB' TYPE SOCKET, NON-ALIGNABLE SYSTEM, NO COVER,	0303	McKesson InterQual® Care Planning; DME
L5540	PREPARATORY, BELOW KNEE 'PTB' TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO	0303	McKesson InterQual® Care Planning; DME
L5560	PREPARATORY, ABOVE KNEE- KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, NON-A	0303	McKesson InterQual® Care Planning; DME
L5570	PREPARATORY, ABOVE KNEE - KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, NON-	0303	McKesson InterQual® Care Planning; DME
L5580	PREPARATORY, ABOVE KNEE - KNEE DISARTICULATION ISCHIAL LEVEL SOCKET, NON-A	0303	McKesson InterQual® Care Planning; DME

L5585	PREPARATORY, ABOVE KNEE - KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, NON-	0303	McKesson InterQual® Care Planning; DME
L5590	PREPARATORY, ABOVE KNEE - KNEE DISARTICULATION ISCHIAL LEVEL SOCKET, NON-A	0303	McKesson InterQual® Care Planning; DME
L5595	PREPARATORY, HIP DISARTICULATION-HEMIPELVECTOMY, PYLON, NO COVER, SACH FOO	0303	DMAS Criteria/DMAS Provider Manual
L5600	PREPARATORY, HIP DISARTICULATION-HEMIPELVECTOMY, PYLON, NO COVER, SACH FOO	0303	DMAS Criteria/DMAS Provider Manual
L5610	ADDITION TO LOWER EXTREMITY, ENDOSKELETAL SYSTEM, ABOVE KNEE, HYDRACADENCE	0303	DMAS Criteria/DMAS Provider Manual
L5611	ADDITION TO LOWER EXTREMITY, ENDOSKELETAL SYSTEM, ABOVE KNEE - KNEE DISART	0303	DMAS Criteria/DMAS Provider Manual
L5613	ADDITION TO LOWER EXTREMITY, ENDOSKELETAL SYSTEM, ABOVE KNEE-KNEE DISARTIC	0303	DMAS Criteria/DMAS Provider Manual
L5614	ADDITION TO LOWER EXTREMITY, EXOSKELETAL SYSTEM, ABOVE KNEE-KNEE DISARTICU	0303	DMAS Criteria/DMAS Provider Manual
L5616	ADDITION TO LOWER EXTREMITY, ENDOSKELETAL SYSTEM, ABOVE KNEE, UNIVERSAL MU	0303	DMAS Criteria/DMAS Provider Manual
L5617	ADDITION TO LOWER EXTREMITY, QUICK CHANGE SELF-ALIGNING UNIT, ABOVE KNEE O	0303	DMAS Criteria/DMAS Provider Manual
L5618	ADDITION TO LOWER EXTREMITY, TEST SOCKET, SYMES	0303	DMAS Criteria/DMAS Provider Manual
L5620	ADDITION TO LOWER EXTREMITY, TEST SOCKET, BELOW KNEE	0303	DMAS Criteria/DMAS Provider Manual
L5622	ADDITION TO LOWER EXTREMITY, TEST SOCKET, KNEE DISARTICULATION	0303	DMAS Criteria/DMAS Provider Manual
L5624	ADDITION TO LOWER EXTREMITY, TEST SOCKET, ABOVE KNEE	0303	DMAS Criteria/DMAS Provider Manual
L5626	ADDITION TO LOWER EXTREMITY, TEST SOCKET, HIP DISARTICULATION	0303	DMAS Criteria/DMAS Provider Manual
L5628	ADDITION TO LOWER EXTREMITY, TEST SOCKET, HEMIPELVECTOMY	0303	DMAS Criteria/DMAS Provider Manual
L5629	ADDITION TO LOWER EXTREMITY, BELOW KNEE, ACRYLIC SOCKET	0303	DMAS Criteria/DMAS Provider Manual
L5630	ADDITION TO LOWER EXTREMITY, SYMES TYPE, EXPANDABLE WALL SOCKET	0303	DMAS Criteria/DMAS Provider Manual
L5631	ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, ACRYLIC S	0303	DMAS Criteria/DMAS Provider Manual

L5632	ADDITION TO LOWER EXTREMITY, SYMES TYPE, 'PTB' BRIM DESIGN SOCKET	0303	DMAS Criteria/DMAS Provider Manual
L5634	ADDITION TO LOWER EXTREMITY, SYMES TYPE, POSTERIOR OPENING (CANADIAN) SOCK	0303	DMAS Criteria/DMAS Provider Manual
L5636	ADDITION TO LOWER EXTREMITY, SYMES TYPE, MEDIAL OPENING SOCKET	0303	DMAS Criteria/DMAS Provider Manual
L5637	ADDITION TO LOWER EXTREMITY, BELOW KNEE, TOTAL CONTACT	0303	DMAS Criteria/DMAS Provider Manual
L5638	ADDITION TO LOWER EXTREMITY, BELOW KNEE, LEATHER SOCKET	0303	DMAS Criteria/DMAS Provider Manual
L5639	ADDITION TO LOWER EXTREMITY, BELOW KNEE, WOOD SOCKET	0303	DMAS Criteria/DMAS Provider Manual
L5640	ADDITION TO LOWER EXTREMITY, KNEE DISARTICULATION, LEATHER SOCKET	0303	DMAS Criteria/DMAS Provider Manual
L5642	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, LEATHER SOCKET	0303	DMAS Criteria/DMAS Provider Manual
L5643	ADDITION TO LOWER EXTREMITY, HIP DISARTICULATION, FLEXIBLE INNER SOCKET,	0303	DMAS Criteria/DMAS Provider Manual
L5644	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, WOOD SOCKET	0303	DMAS Criteria/DMAS Provider Manual
L5645	ADDITION TO LOWER EXTREMITY, BELOW KNEE, FLEXIBLE INNER SOCKET, EXTERNAL	0303	DMAS Criteria/DMAS Provider Manual
L5646	ADDITION TO LOWER EXTREMITY, BELOW KNEE, AIR CUSHION SOCKET	0303	DMAS Criteria/DMAS Provider Manual
L5647	ADDITION TO LOWER EXTREMITY, BELOW KNEE SUCTION SOCKET	0303	DMAS Criteria/DMAS Provider Manual
L5648	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, AIR CUSHION SOCKET	0303	DMAS Criteria/DMAS Provider Manual
L5649	ADDITION TO LOWER EXTREMITY, ISCHIAL CONTAINMENT/NARROW M-L SOCKET	0303	DMAS Criteria/DMAS Provider Manual
L5650	ADDITIONS TO LOWER EXTREMITY, TOTAL CONTACT, ABOVE KNEE OR KNEE DISARTICUL	0303	DMAS Criteria/DMAS Provider Manual
L5651	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, FLEXIBLE INNER SOCKET, EXTERNAL	0303	DMAS Criteria/DMAS Provider Manual
L5652	ADDITION TO LOWER EXTREMITY, SUCTION SUSPENSION, ABOVE KNEE OR KNEE DISAR	0303	DMAS Criteria/DMAS Provider Manual
L5653	ADDITION TO LOWER EXTREMITY, KNEE DISARTICULATION, EXPANDABLE WALL SOCKET	0303	DMAS Criteria/DMAS Provider Manual

L5654	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, SYMES, (KEMBLO, PELITE, ALIPL	0303	DMAS Criteria/DMAS Provider Manual
L5655	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, BELOW KNEE (KEMBLO, PELITE,	0303	DMAS Criteria/DMAS Provider Manual
L5656	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, KNEE DISARTICULATION (KEMBLO,	0303	DMAS Criteria/DMAS Provider Manual
L5658	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, ABOVE KNEE (KEMBLO, PELITE,	0303	DMAS Criteria/DMAS Provider Manual
L5661	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, MULTI-DUROMETER SYMES	0303	DMAS Criteria/DMAS Provider Manual
L5665	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, MULTI-DUROMETER, BELOW KNEE	0303	DMAS Criteria/DMAS Provider Manual
L5666	ADDITION TO LOWER EXTREMITY, BELOW KNEE, CUFF SUSPENSION	0303	DMAS Criteria/DMAS Provider Manual
L5668	ADDITION TO LOWER EXTREMITY, BELOW KNEE, MOLDED DISTAL CUSHION	0303	DMAS Criteria/DMAS Provider Manual
L5670	ADDITION TO LOWER EXTREMITY, BELOW KNEE, MOLDED SUPRACONDYLAR SUSPENSION	0303	DMAS Criteria/DMAS Provider Manual
L5671	ADDITION TO LOWER EXTREMITY, BELOW KNEE / ABOVE KNEE SUSPENSION LOCKING ME	0303	DMAS Criteria/DMAS Provider Manual
L5672	ADDITION TO LOWER EXTREMITY, BELOW KNEE, REMOVABLE MEDIAL BRIM SUSPENSION	0303	DMAS Criteria/DMAS Provider Manual
L5673	ADDITION TO LOWER EXTREMITY, BELOW KNEE/ABOVE KNEE, CUSTOM FABRICATED FROM	0303	DMAS Criteria/DMAS Provider Manual
L5676	ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, KNEE JOINTS, SINGLE AXIS, PAIR	0303	DMAS Criteria/DMAS Provider Manual
L5677	ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, KNEE JOINTS, POLYCENTRIC, PAIR	0303	DMAS Criteria/DMAS Provider Manual
L5678	ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, JOINT COVERS, PAIR	0303	DMAS Criteria/DMAS Provider Manual
L5679	ADDITION TO LOWER EXTREMITY, BELOW KNEE/ABOVE KNEE, CUSTOM FABRICATED FROM	0303	DMAS Criteria/DMAS Provider Manual
L5680	ADDITION TO LOWER EXTREMITY, BELOW KNEE, THIGH LACER, NONMOLDED	0303	DMAS Criteria/DMAS Provider Manual
L5681	ADDITION TO LOWER EXTREMITY, BELOW KNEE/ABOVE KNEE, CUSTOM FABRICATED SOCKET	0303	DMAS Criteria/DMAS Provider Manual
L5682	ADDITION TO LOWER EXTREMITY, BELOW KNEE, THIGH LACER, GLUTEAL/ISCHIAL, MO	0303	DMAS Criteria/DMAS Provider Manual

L5683	ADDITION TO LOWER EXTREMITY, BELOW KNEE/ABOVE KNEE, CUSTOM FABRICATED SOCKET	0303	DMAS Criteria/DMAS Provider Manual
L5684	ADDITION TO LOWER EXTREMITY, BELOW KNEE, FORK STRAP	0303	DMAS Criteria/DMAS Provider Manual
L5685	ADDITION TO LOWER EXTREMITY PROSTHESIS, BELOW KNEE, SUSPENSION/SEALING SLEEVE,	0303	DMAS Criteria/DMAS Provider Manual
L5686	ADDITION TO LOWER EXTREMITY, BELOW KNEE, BACK CHECK (EXTENSION CONTROL)	0303	DMAS Criteria/DMAS Provider Manual
L5688	ADDITION TO LOWER EXTREMITY, BELOW KNEE, WAIST BELT, WEBBING	0303	DMAS Criteria/DMAS Provider Manual
L5690	ADDITION TO LOWER EXTREMITY, BELOW KNEE, WAIST BELT, PADDED AND LINED	0303	DMAS Criteria/DMAS Provider Manual
L5692	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, PELVIC CONTROL BELT, LIGHT	0303	DMAS Criteria/DMAS Provider Manual
L5694	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, PELVIC CONTROL BELT, PADDED AND	0303	DMAS Criteria/DMAS Provider Manual
L5695	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, PELVIC CONTROL, SLEEVE SUSPENSION	0303	DMAS Criteria/DMAS Provider Manual
L5696	ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, PELVIC J	0303	DMAS Criteria/DMAS Provider Manual
L5697	ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, PELVIC B	0303	DMAS Criteria/DMAS Provider Manual
L5698	ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, SILESIAN	0303	DMAS Criteria/DMAS Provider Manual
L5699	ALL LOWER EXTREMITY PROSTHESES, SHOULDER HARNESS	0303	DMAS Criteria/DMAS Provider Manual
L5700	REPLACEMENT, SOCKET, BELOW KNEE, MOLDED TO PATIENT MODEL	0303	McKesson InterQual® Care Planning; DME
L5701	REPLACEMENT, SOCKET, ABOVE KNEE/KNEE DISARTICULATION, INCLUDING ATTACHMENT	0303	McKesson InterQual® Care Planning; DME
L5702	REPLACEMENT, SOCKET, HIP DISARTICULATION, INCLUDING HIP JOINT, MOLDED TO	0303	DMAS Criteria/DMAS Provider Manual
L5703	ANKLE SYMES MOLDED TO PATIENT MODEL	0303	DMAS Criteria/DMAS Provider Manual
L5704	CUSTOM SHAPED PROTECTIVE COVER, BELOW KNEE	0303	DMAS Criteria/DMAS Provider Manual
L5705	CUSTOM SHAPED PROTECTIVE COVER, ABOVE KNEE	0303	DMAS Criteria/DMAS Provider Manual
L5706	CUSTOM SHAPED PROTECTIVE COVER, KNEE DISARTICULATION	0303	DMAS Criteria/DMAS Provider Manual
L5707	CUSTOM SHAPED PROTECTIVE COVER, HIP DISARTICULATION	0303	DMAS Criteria/DMAS Provider Manual

L5710	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK	0303	DMAS Criteria/DMAS Provider Manual
L5711	ADDITIONS EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK, ULTRA-LI	0303	DMAS Criteria/DMAS Provider Manual
L5712	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FRICTION SWING AND S	0303	DMAS Criteria/DMAS Provider Manual
L5714	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, VARIABLE FRICTION SW	0303	DMAS Criteria/DMAS Provider Manual
L5716	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, MECHANICAL STANCE PH	0303	DMAS Criteria/DMAS Provider Manual
L5718	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, FRICTION SWING AND	0303	DMAS Criteria/DMAS Provider Manual
L5722	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC SWING, FRI	0303	DMAS Criteria/DMAS Provider Manual
L5724	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING PHASE CO	0303	DMAS Criteria/DMAS Provider Manual
L5726	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, EXTERNAL JOINTS FLUI	0303	DMAS Criteria/DMAS Provider Manual
L5728	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STAN	0303	DMAS Criteria/DMAS Provider Manual
L5780	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC/HYDRA PNEU	0303	DMAS Criteria/DMAS Provider Manual
L5781	ADDITION TO LOWER LIMB PROSTHESIS, VACUUM PUMP, RESIDUAL LIMB VOLUME MANAG	0303	DMAS Criteria/DMAS Provider Manual
L5782	ADDITION TO LOWER LIMB PROSTHESIS, VACUUM PUMP, RESIDUAL LIMB VOLUME MANAG	0303	DMAS Criteria/DMAS Provider Manual
L5785	ADDITION, EXOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL (TITANIUM,	0303	DMAS Criteria/DMAS Provider Manual
L5790	ADDITION, EXOSKELETAL SYSTEM, ABOVE KNEE, ULTRA-LIGHT MATERIAL (TITANIUM,	0303	DMAS Criteria/DMAS Provider Manual
L5795	ADDITION, EXOSKELETAL SYSTEM, HIP DISARTICULATION, ULTRA-LIGHT MATERIAL (T	0303	DMAS Criteria/DMAS Provider Manual
L5810	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK	0303	DMAS Criteria/DMAS Provider Manual
L5811	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK, ULTRA-L	0303	DMAS Criteria/DMAS Provider Manual
L5812	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FRICTION SWING AND S	0303	DMAS Criteria/DMAS Provider Manual

L5814	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, HYDRAULIC SWING PHAS	0303	DMAS Criteria/DMAS Provider Manual
L5816	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, MECHANICAL STANCE PH	0303	DMAS Criteria/DMAS Provider Manual
L5818	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, FRICTION SWING, AND	0303	DMAS Criteria/DMAS Provider Manual
L5822	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC SWING, FRI	0303	DMAS Criteria/DMAS Provider Manual
L5824	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING PHASE CO	0303	DMAS Criteria/DMAS Provider Manual
L5826	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, HYDRAULIC SWING PHAS	0303	DMAS Criteria/DMAS Provider Manual
L5828	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STAN	0303	DMAS Criteria/DMAS Provider Manual
L5830	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC/ SWING PHA	0303	DMAS Criteria/DMAS Provider Manual
L5840	ADDITION, ENDOSKELETAL KNEE/SHIN SYSTEM, 4-BAR LINKAGE OR MULTIAXIAL, PNEU	0303	DMAS Criteria/DMAS Provider Manual
L5845	ADDITION, ENDOSKELETAL, KNEE-SHIN SYSTEM, STANCE FLEXION FEATURE, ADJUSTAB	0303	DMAS Criteria/DMAS Provider Manual
L5848	ADDITION TO ENDOSKELETAL, KNEE-SHIN SYSTEM, HYDRAULIC STANCE EXTENSION, DA	0303	DMAS Criteria/DMAS Provider Manual
L5850	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE OR HIP DISARTICULATION, KNEE EX	0303	DMAS Criteria/DMAS Provider Manual
L5855	ADDITION, ENDOSKELETAL SYSTEM, HIP DISARTICULATION, MECHANICAL HIP EXTENSI	0303	DMAS Criteria/DMAS Provider Manual
L5856	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM,	0303	McKesson InterQual® Care Planning; DME
L5857	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM,	0303	McKesson InterQual® Care Planning; DME
L5858	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE SHIN SYSTEM,	0303	McKesson InterQual® Care Planning; DME
L5910	ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, ALIGNABLE SYSTEM	0303	DMAS Criteria/DMAS Provider Manual
L5920	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE OR HIP DISARTICULATION, ALIGNABL	0303	DMAS Criteria/DMAS Provider Manual
L5925	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE, KNEE DISARTICULATION OR HIP DIS	0303	DMAS Criteria/DMAS Provider Manual

L5930	ADDITION, ENDOSKELETAL SYSTEM, HIGH ACTIVITY KNEE CONTROL FRAME	0303	DMAS Criteria/DMAS Provider Manual
L5940	ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL (TITANIUM	0303	DMAS Criteria/DMAS Provider Manual
L5950	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE, ULTRA-LIGHT MATERIAL (TITANIUM	0303	DMAS Criteria/DMAS Provider Manual
L5960	ADDITION, ENDOSKELETAL SYSTEM, HIP DISARTICULATION, ULTRA-LIGHT MATERIAL	0303	DMAS Criteria/DMAS Provider Manual
L5962	ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, FLEXIBLE PROTECTIVE OUTER SURFA	0303	DMAS Criteria/DMAS Provider Manual
L5964	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE, FLEXIBLE PROTECTIVE OUTER SURFA	0303	DMAS Criteria/DMAS Provider Manual
L5966	ADDITION, ENDOSKELETAL SYSTEM, HIP DISARTICULATION, FLEXIBLE PROTECTIVE OU	0303	DMAS Criteria/DMAS Provider Manual
L5968	ADDITION TO LOWER LIMB PROSTHESIS, MULTIAXIAL ANKLE WITH SWING PHASE ACTIV	0303	DMAS Criteria/DMAS Provider Manual
L5970	ALL LOWER EXTREMITY PROSTHESES, FOOT, EXTERNAL KEEL, SACH FOOT	0303	DMAS Criteria/DMAS Provider Manual
L5971	ALL LOWER EXTREMITY PROSTHESIS, SOLID ANKLE CUSHION HEEL (SACH) FOOT,	0303	DMAS Criteria/DMAS Provider Manual
L5972	ALL LOWER EXTREMITY PROSTHESES, FLEXIBLE KEEL FOOT (SAFE, STEN, BOCK DYNAM	0303	DMAS Criteria/DMAS Provider Manual
L5973	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION	0303	DMAS Criteria/DMAS Provider Manual
L5974	ALL LOWER EXTREMITY PROSTHESES, FOOT, SINGLE AXIS ANKLE/FOOT	0303	DMAS Criteria/DMAS Provider Manual
L5975	ALL LOWER EXTREMITY PROSTHESIS, COMBINATION SINGLE AXIS ANKLE AND FLEXIBLE	0303	DMAS Criteria/DMAS Provider Manual
L5976	ALL LOWER EXTREMITY PROSTHESES, ENERGY STORING FOOT (SEATTLE CARBON COPY I	0303	DMAS Criteria/DMAS Provider Manual
L5978	ALL LOWER EXTREMITY PROSTHESES, FOOT, MULTIAXIAL ANKLE/FOOT	0303	DMAS Criteria/DMAS Provider Manual
L5979	ALL LOWER EXTREMITY PROSTHESIS, MULTI-AXIAL ANKLE, DYNAMIC RESPONSE FOOT,	0303	DMAS Criteria/DMAS Provider Manual
L5980	ALL LOWER EXTREMITY PROSTHESES, FLEX FOOT SYSTEM	0303	DMAS Criteria/DMAS Provider Manual
L5981	ALL LOWER EXTREMITY PROSTHESES, FLEX-WALK SYSTEM OR EQUAL	0303	DMAS Criteria/DMAS Provider Manual

L5982	ALL EXOSKELETAL LOWER EXTREMITY PROSTHESES, AXIAL ROTATION UNIT	0303	DMAS Criteria/DMAS Provider Manual
L5984	ALL ENDOSKELETAL LOWER EXTREMITY PROSTHESES, AXIAL ROTATION UNIT	0303	DMAS Criteria/DMAS Provider Manual
L5985	ALL ENDOSKELETAL LOWER EXTREMITY PROTHESES, DYNAMIC PROSTHETIC PYLON	0303	DMAS Criteria/DMAS Provider Manual
L5986	ALL LOWER EXTREMITY PROSTHESES, MULTI-AXIAL ROTATION UNIT ('MCP' OR EQUAL)	0303	DMAS Criteria/DMAS Provider Manual
L5987	ALL LOWER EXTREMITY PROSTHESIS, SHANK FOOT SYSTEM WITH VERTICAL LOADING PY	0303	DMAS Criteria/DMAS Provider Manual
L5988	ADDITION TO LOWER LIMB PROSTHESIS, VERTICAL SHOCK REDUCING PYLON FEATURE	0303	DMAS Criteria/DMAS Provider Manual
L5990	ADDITION TO LOWER EXTREMITY PROSTHESIS, USER ADJUSTABLE HEEL HEIGHT	0303	DMAS Criteria/DMAS Provider Manual
L5999	LOWER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED	0303	DMAS Criteria/DMAS Provider Manual
L6000	PARTIAL HAND, ROBIN-AIDS, THUMB REMAINING (OR EQUAL)	0303	DMAS Criteria/DMAS Provider Manual
L6010	PARTIAL HAND, ROBIN-AIDS, LITTLE AND/OR RING FINGER REMAINING (OR EQUAL)	0303	DMAS Criteria/DMAS Provider Manual
L6020	PARTIAL HAND, ROBIN-AIDS, NO FINGER REMAINING (OR EQUAL)	0303	DMAS Criteria/DMAS Provider Manual
L6025	TRANSCARPAL/METACARPAL OR PARTIAL HAND DISARTICULATION PROSTHESIS, EXTERNA	0303	DMAS Criteria/DMAS Provider Manual
L6050	WRIST DISARTICULATION, MOLDED SOCKET, FLEXIBLE ELBOW HINGES, TRICEPS PAD	0303	DMAS Criteria/DMAS Provider Manual
L6055	WRIST DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, FLEXIBLE E	0303	DMAS Criteria/DMAS Provider Manual
L6100	BELOW ELBOW, MOLDED SOCKET, FLEXIBLE ELBOW HINGE, TRICEPS PAD	0303	DMAS Criteria/DMAS Provider Manual
L6110	BELOW ELBOW, MOLDED SOCKET, (MUENSTER OR NORTHWESTERN SUSPENSION TYPES)	0303	DMAS Criteria/DMAS Provider Manual
L6120	BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STEP-UP HINGES, HALF CUFF	0303	DMAS Criteria/DMAS Provider Manual
L6130	BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STUMP ACTIVATED LOCKING HING	0303	DMAS Criteria/DMAS Provider Manual
L6200	ELBOW DISARTICULATION, MOLDED SOCKET, OUTSIDE LOCKING HINGE, FOREARM	0303	DMAS Criteria/DMAS Provider Manual

L6205	ELBOW DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, OUTSIDE LO	0303	DMAS Criteria/DMAS Provider Manual
L6250	ABOVE ELBOW, MOLDED DOUBLE WALL SOCKET, INTERNAL LOCKING ELBOW, FOREARM	0303	DMAS Criteria/DMAS Provider Manual
L6300	SHOULDER DISARTICULATION, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTIO	0303	DMAS Criteria/DMAS Provider Manual
L6310	SHOULDER DISARTICULATION, PASSIVE RESTORATION (COMPLETE PROSTHESIS)	0303	DMAS Criteria/DMAS Provider Manual
L6320	SHOULDER DISARTICULATION, PASSIVE RESTORATION (SHOULDER CAP ONLY)	0303	DMAS Criteria/DMAS Provider Manual
L6350	INTERSCAPULAR THORACIC, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION,	0303	DMAS Criteria/DMAS Provider Manual
L6360	INTERSCAPULAR THORACIC, PASSIVE RESTORATION (COMPLETE PROSTHESIS)	0303	DMAS Criteria/DMAS Provider Manual
L6370	INTERSCAPULAR THORACIC, PASSIVE RESTORATION (SHOULDER CAP ONLY)	0303	DMAS Criteria/DMAS Provider Manual
L6380	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRE	0303	DMAS Criteria/DMAS Provider Manual
L6382	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRE	0303	DMAS Criteria/DMAS Provider Manual
L6384	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRE	0303	DMAS Criteria/DMAS Provider Manual
L6386	IMMEDIATE POST SURGICAL OR EARLY FITTING, EACH ADDITIONAL CAST CHANGE AND	0303	DMAS Criteria/DMAS Provider Manual
L6388	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF RIGID DRESSING ON	0303	DMAS Criteria/DMAS Provider Manual
L6400	BELOW ELBOW, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC	0303	DMAS Criteria/DMAS Provider Manual
L6450	ELBOW DISARTICULATION, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT	0303	DMAS Criteria/DMAS Provider Manual
L6500	ABOVE ELBOW, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC	0303	DMAS Criteria/DMAS Provider Manual
L6550	SHOULDER DISARTICULATION, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SO	0303	DMAS Criteria/DMAS Provider Manual
L6570	INTERSCAPULAR THORACIC, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT	0303	DMAS Criteria/DMAS Provider Manual
L6580	PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL PLASTIC SOC	0303	DMAS Criteria/DMAS Provider Manual

L6582	PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL SOCKET, FRI	0303	DMAS Criteria/DMAS Provider Manual
L6584	PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL PLASTIC SOC	0303	DMAS Criteria/DMAS Provider Manual
L6586	PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL SOCKET, FRI	0303	DMAS Criteria/DMAS Provider Manual
L6588	PREPARATORY, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC, SINGLE WA	0303	DMAS Criteria/DMAS Provider Manual
L6590	PREPARATORY, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC, SINGLE WA	0303	DMAS Criteria/DMAS Provider Manual
L6600	UPPER EXTREMITY ADDITIONS, POLYCENTRIC HINGE, PAIR	0303	DMAS Criteria/DMAS Provider Manual
L6605	UPPER EXTREMITY ADDITIONS, SINGLE PIVOT HINGE, PAIR	0303	DMAS Criteria/DMAS Provider Manual
L6610	UPPER EXTREMITY ADDITIONS, FLEXIBLE METAL HINGE, PAIR	0303	DMAS Criteria/DMAS Provider Manual
L6615	UPPER EXTREMITY ADDITION, DISCONNECT LOCKING WRIST UNIT	0303	DMAS Criteria/DMAS Provider Manual
L6616	UPPER EXTREMITY ADDITION, ADDITIONAL DISCONNECT INSERT FOR LOCKING WRIST U	0303	DMAS Criteria/DMAS Provider Manual
L6620	UPPER EXTREMITY ADDITION, FLEXION-FRICTION WRIST UNIT	0303	DMAS Criteria/DMAS Provider Manual
L6621	UPPER EXTREMITY PROSTHESIS ADDITION, FLEXION/EXTENSION WRIST WITH OR WITHOUT	0303	DMAS Criteria/DMAS Provider Manual
L6623	UPPER EXTREMITY ADDITION, SPRING ASSISTED ROTATIONAL WRIST UNIT WITH LATC	0303	DMAS Criteria/DMAS Provider Manual
L6625	UPPER EXTREMITY ADDITION, ROTATION WRIST UNIT WITH CABLE LOCK	0303	DMAS Criteria/DMAS Provider Manual
L6628	UPPER EXTREMITY ADDITION, QUICK DISCONNECT HOOK ADAPTER, OTTO BOCK OR EQU	0303	DMAS Criteria/DMAS Provider Manual
L6629	UPPER EXTREMITY ADDITION, QUICK DISCONNECT LAMINATION COLLAR WITH COUPLIN	0303	DMAS Criteria/DMAS Provider Manual
L6630	UPPER EXTREMITY ADDITION, STAINLESS STEEL, ANY WRIST	0303	DMAS Criteria/DMAS Provider Manual
L6632	UPPER EXTREMITY ADDITION, LATEX SUSPENSION SLEEVE, EACH	0303	DMAS Criteria/DMAS Provider Manual
L6635	UPPER EXTREMITY ADDITION, LIFT ASSIST FOR ELBOW	0303	DMAS Criteria/DMAS Provider Manual

L6637	UPPER EXTREMITY ADDITION, NUDGE CONTROL ELBOW LOCK	0303	DMAS Criteria/DMAS Provider Manual
L6638	UPPER EXTREMITY ADDITION TO PROSTHESIS, ELECTRIC LOCKING FEATURE, ONLY FOR	0303	DMAS Criteria/DMAS Provider Manual
L6640	UPPER EXTREMITY ADDITIONS, SHOULDER ABDUCTION JOINT, PAIR	0303	DMAS Criteria/DMAS Provider Manual
L6641	UPPER EXTREMITY ADDITION, EXCURSION AMPLIFIER, PULLEY TYPE	0303	DMAS Criteria/DMAS Provider Manual
L6642	UPPER EXTREMITY ADDITION, EXCURSION AMPLIFIER, LEVER TYPE	0303	DMAS Criteria/DMAS Provider Manual
L6645	UPPER EXTREMITY ADDITION, SHOULDER FLEXION-ABDUCTION JOINT, EACH	0303	DMAS Criteria/DMAS Provider Manual
L6646	UPPER EXTREMITY ADDITION, SHOULDER JOINT, MULTIPOSITIONAL LOCKING, FLEXION	0303	DMAS Criteria/DMAS Provider Manual
L6647	UPPER EXTREMITY ADDITION, SHOULDER LOCK MECHANISM, BODY POWERED ACTUATOR	0303	DMAS Criteria/DMAS Provider Manual
L6648	UPPER EXTREMITY ADDITION, SHOULDER LOCK MECHANISM, EXTERNAL POWERED ACTUAT	0303	DMAS Criteria/DMAS Provider Manual
L6650	UPPER EXTREMITY ADDITION, SHOULDER UNIVERSAL JOINT, EACH	0303	DMAS Criteria/DMAS Provider Manual
L6655	UPPER EXTREMITY ADDITION, STANDARD CONTROL CABLE, EXTRA	0303	DMAS Criteria/DMAS Provider Manual
L6660	UPPER EXTREMITY ADDITION, HEAVY DUTY CONTROL CABLE	0303	DMAS Criteria/DMAS Provider Manual
L6665	UPPER EXTREMITY ADDITION, TEFLON, OR EQUAL, CABLE LINING	0303	DMAS Criteria/DMAS Provider Manual
L6670	UPPER EXTREMITY ADDITION, HOOK TO HAND, CABLE ADAPTER	0303	DMAS Criteria/DMAS Provider Manual
L6672	UPPER EXTREMITY ADDITION, HARNESS, CHEST OR SHOULDER, SADDLE TYPE	0303	DMAS Criteria/DMAS Provider Manual
L6675	UPPER EXTREMITY ADDITION, HARNESS, FIGURE OF ('8') EIGHT TYPE, FOR SINGLE	0303	DMAS Criteria/DMAS Provider Manual
L6676	UPPER EXTREMITY ADDITION, HARNESS, FIGURE OF ('8') EIGHT TYPE, FOR DUAL C	0303	DMAS Criteria/DMAS Provider Manual
L6677	UPPER EXTREMITY ADDITION, HARNESS, TRIPLE CONTROL, SIMULTANEOUS OPERATION OF	0303	DMAS Criteria/DMAS Provider Manual
L6680	UPPER EXTREMITY ADDITION, TEST SOCKET, WRIST DISARTICULATION OR BELOW ELB	0303	DMAS Criteria/DMAS Provider Manual

L6682	UPPER EXTREMITY ADDITION, TEST SOCKET, ELBOW DISARTICULATION OR ABOVE ELB	0303	DMAS Criteria/DMAS Provider Manual
L6684	UPPER EXTREMITY ADDITION, TEST SOCKET, SHOULDER DISARTICULATION OR INTERS	0303	DMAS Criteria/DMAS Provider Manual
L6686	UPPER EXTREMITY ADDITION, SUCTION SOCKET	0303	DMAS Criteria/DMAS Provider Manual
L6687	UPPER EXTREMITY ADDITION, FRAME TYPE SOCKET, BELOW ELBOW OR WRIST DISARTIC	0303	DMAS Criteria/DMAS Provider Manual
L6688	UPPER EXTREMITY ADDITION, FRAME TYPE SOCKET, ABOVE ELBOW OR ELBOW DISARTIC	0303	DMAS Criteria/DMAS Provider Manual
L6689	UPPER EXTREMITY ADDITION, FRAME TYPE SOCKET, SHOULDER DISARTICULATION	0303	DMAS Criteria/DMAS Provider Manual
L6690	UPPER EXTREMITY ADDITION, FRAME TYPE SOCKET, INTERSCAPULAR-THORACIC	0303	DMAS Criteria/DMAS Provider Manual
L6691	UPPER EXTREMITY ADDITION, REMOVABLE INSERT, EACH	0303	DMAS Criteria/DMAS Provider Manual
L6692	UPPER EXTREMITY ADDITION, SILICONE GEL INSERT OR EQUAL, EACH	0303	DMAS Criteria/DMAS Provider Manual
L6693	UPPER EXTREMITY ADDITION, LOCKING ELBOW, FOREARM COUNTERBALANCE	0303	DMAS Criteria/DMAS Provider Manual
L6694	ADDITION TO UPPER EXTREMITY PROSTHESIS, BELOW ELBOW/ABOVE ELBOW, CUSTOM	0303	DMAS Criteria/DMAS Provider Manual
L6695	ADDITION TO UPPER EXTREMITY PROSTHESIS, BELOW ELBOW/ABOVE ELBOW, CUSTOM	0303	DMAS Criteria/DMAS Provider Manual
L6696	ADDITION TO UPPER EXTREMITY PROSTHESIS, BELOW ELBOW/ABOVE ELBOW, CUSTOM	0303	DMAS Criteria/DMAS Provider Manual
L6697	ADDITION TO UPPER EXTREMITY PROSTHESIS, BELOW ELBOW/ABOVE ELBOW, CUSTOM	0303	DMAS Criteria/DMAS Provider Manual
L6698	ADDITION TO UPPER EXTREMITY PROSTHESIS, BELOW ELBOW/ABOVE ELBOW, LOCK	0303	DMAS Criteria/DMAS Provider Manual
L6703	TERMINAL DEVICE, PASSIVE HAND/MITT, ANY MATERIAL, ANY SIZE	0303	DMAS Criteria/DMAS Provider Manual
L6706	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE,	0303	DMAS Criteria/DMAS Provider Manual
L6707	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE,	0303	DMAS Criteria/DMAS Provider Manual
L6708	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE	0303	DMAS Criteria/DMAS Provider Manual
L6709	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE	0303	DMAS Criteria/DMAS Provider Manual

L6711	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE,	0303	DMAS Criteria/DMAS Provider Manual
L6721	TERMINAL DEVICE, HOOK OR HAND, HEAVY DUTY, MECHANICAL, VOLUNTARY OPENING, ANY	0303	DMAS Criteria/DMAS Provider Manual
L6790	TERMINAL DEVICE, HOOK-ACCU HOOK, OR EQUAL	0303	DMAS Criteria/DMAS Provider Manual
L6795	TERMINAL DEVICE, HOOK-2 LOAD, OR EQUAL	0303	DMAS Criteria/DMAS Provider Manual
L6800	TERMINAL DEVICE, HOOK-APRL VC, OR EQUAL	0303	DMAS Criteria/DMAS Provider Manual
L6805	TERMINAL DEVICE, MODIFIER WRIST FLEXION UNIT	0303	DMAS Criteria/DMAS Provider Manual
L6810	TERMINAL DEVICE, PINCHER TOOL, OTTO BOCK OR EQUAL	0303	DMAS Criteria/DMAS Provider Manual
L6881	AUTOMATIC GRASP FEATURE, ADDITION TO UPPER LIMB PROSTHETIC TERMINAL DEVICE	0303	DMAS Criteria/DMAS Provider Manual
L6882	MICROPROCESSOR CONTROL FEATURE, ADDITION TO UPPER LIMB PROSTHETIC TERMINAL	0303	DMAS Criteria/DMAS Provider Manual
L6883	REPLACEMENT SOCKET, BELOW ELBOW/WRIST DISARTICULATION, MOLDED TO PATIENT MODEL,	0303	DMAS Criteria/DMAS Provider Manual
L6884	REPLACEMENT SOCKET, ABOVE ELBOW DISARTICULATION, MOLDED TO PATIENT MODEL, FOR	0303	DMAS Criteria/DMAS Provider Manual
L6885	REPLACEMENT SOCKET, SHOULDER DISARTICULATION/INTERSCAPULAR THORACIC, MOLDED TO	0303	DMAS Criteria/DMAS Provider Manual
L6890	TERMINAL DEVICE, GLOVE FOR ABOVE HANDS, PRODUCTION GLOVE	0303	DMAS Criteria/DMAS Provider Manual
L6895	TERMINAL DEVICE, GLOVE FOR ABOVE HANDS, CUSTOM GLOVE	0303	DMAS Criteria/DMAS Provider Manual
L6900	HAND RESTORATION (CASTS, SHADING AND MEASUREMENTS INCLUDED), PARTIAL HAND,	0303	DMAS Criteria/DMAS Provider Manual
L6905	HAND RESTORATION (CASTS, SHADING AND MEASUREMENTS INCLUDED), PARTIAL HAND,	0303	DMAS Criteria/DMAS Provider Manual
L6910	HAND RESTORATION (CASTS, SHADING AND MEASUREMENTS INCLUDED), PARTIAL HAND,	0303	DMAS Criteria/DMAS Provider Manual
L6915	HAND RESTORATION (SHADING, AND MEASUREMENTS INCLUDED), REPLACEMENT GLOVE F	0303	DMAS Criteria/DMAS Provider Manual
L6920	WRIST DISARTICULATION, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVA	0303	DMAS Criteria/DMAS Provider Manual
L6925	WRIST DISARTICULATION, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVA	0303	DMAS Criteria/DMAS Provider Manual
L6930	BELOW ELBOW, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREAR	0303	DMAS Criteria/DMAS Provider Manual

L6935	BELOW ELBOW, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREAR	0303	DMAS Criteria/DMAS Provider Manual
L6940	ELBOW DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE HUME	0303	DMAS Criteria/DMAS Provider Manual
L6945	ELBOW DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE HUME	0303	DMAS Criteria/DMAS Provider Manual
L6950	ABOVE ELBOW, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE HUMERAL SHELL,	0303	DMAS Criteria/DMAS Provider Manual
L6955	ABOVE ELBOW, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE HUMERAL SHELL,	0303	DMAS Criteria/DMAS Provider Manual
L6960	SHOULDER DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE	0303	DMAS Criteria/DMAS Provider Manual
L6965	SHOULDER DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE	0303	DMAS Criteria/DMAS Provider Manual
L6970	INTERSCAPULAR-THORACIC, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHO	0303	DMAS Criteria/DMAS Provider Manual
L6975	INTERSCAPULAR-THORACIC, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHO	0303	DMAS Criteria/DMAS Provider Manual
L7007	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	0303	DMAS Criteria/DMAS Provider Manual
L7009	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, ADULT	0303	DMAS Criteria/DMAS Provider Manual
L7040	PREHENSILE ACTUATOR, HOSMER OR EQUAL, SWITCH CONTROLLED	0303	DMAS Criteria/DMAS Provider Manual
L7045	ELECTRONIC HOOK, CHILD, MICHIGAN OR EQUAL, SWITCH CONTROLLED	0303	DMAS Criteria/DMAS Provider Manual
L7170	ELECTRONIC ELBOW, HOSMER OR EQUAL, SWITCH CONTROLLED	0303	DMAS Criteria/DMAS Provider Manual
L7180	ELECTRONIC ELBOW, BOSTON, UTAH OR EQUAL, MYOELECTRONICALLY CONTROLLED	0303	DMAS Criteria/DMAS Provider Manual
L7181	ELECTRONIC ELBOW, MICROPROCESSOR SIMULTANEOUS CONTROL OF ELBOW AND TERMINAL	0303	DMAS Criteria/DMAS Provider Manual
L7185	ELECTRONIC ELBOW, ADOLESCENT, VARIETY VILLAGE OR EQUAL, SWITCH CONTROLLED	0303	DMAS Criteria/DMAS Provider Manual
L7186	ELECTRONIC ELBOW, CHILD, VARIETY VILLAGE OR EQUAL, SWITCH CONTROLLED	0303	DMAS Criteria/DMAS Provider Manual
L7190	ELECTRONIC ELBOW, ADOLESCENT, VARIETY VILLAGE OR EQUAL, MYOELECTRONICALLY	0303	DMAS Criteria/DMAS Provider Manual

L7191	ELECTRONIC ELBOW, CHILD, VARIETY VILLAGE OR EQUAL, MYOELECTRONICALLY CONTR	0303	DMAS Criteria/DMAS Provider Manual
L7260	ELECTRONIC WRIST ROTATOR, OTTO BOCK OR EQUAL	0303	DMAS Criteria/DMAS Provider Manual
L7261	ELECTRONIC WRIST ROTATOR, FOR UTAH ARM	0303	DMAS Criteria/DMAS Provider Manual
L7266	SERVO CONTROL, STEEPER OR EQUAL	0303	DMAS Criteria/DMAS Provider Manual
L7272	ANALOGUE CONTROL, UNB OR EQUAL	0303	DMAS Criteria/DMAS Provider Manual
L7274	PROPORTIONAL CONTROL, 6-12 VOLT, LIBERTY, UTAH OR EQUAL	0303	DMAS Criteria/DMAS Provider Manual
L7368	LITHIUM ION BATTERY CHARGER	0303	DMAS Criteria/DMAS Provider Manual
L7400	ADDITION TO UPPER EXTREMITY PROSTHESIS, BELOW ELBOW/WRIST DISARTICULATION,	0303	DMAS Criteria/DMAS Provider Manual
L7401	ADDITION TO UPPER EXTREMITY PROSTHESIS, ABOVE ELBOW DISARTICULATION, ULTRALIGHT	0303	DMAS Criteria/DMAS Provider Manual
L7402	ADDITION TO UPPER EXTREMITY PROSTHESIS, SHOULDER DISARTICULATION/INTERSCAPULAR	0303	DMAS Criteria/DMAS Provider Manual
L7403	ADDITION TO UPPER EXTREMITY PROSTHESIS, BELOW ELBOW/WRIST DISARTICULATION,	0303	DMAS Criteria/DMAS Provider Manual
L7404	ADDITION TO UPPER EXTREMITY PROSTHESIS, ABOVE ELBOW DISARTICULATION, ACRYLIC	0303	DMAS Criteria/DMAS Provider Manual
L7405	ADDITION TO UPPER EXTREMITY PROSTHESIS, SHOULDER DISARTICULATION/INTERSCAPULAR	0303	DMAS Criteria/DMAS Provider Manual
L7499	UPPER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED	0303	DMAS Criteria/DMAS Provider Manual
L7500	REPAIR OF PROSTHETIC DEVICE, HOURLY RATE (EXCLUDES V5335 REPAIR OF ORAL OR	0303	DMAS Criteria/DMAS Provider Manual
L7510	REPAIR OF PROSTHETIC DEVICE, REPAIR OR REPLACE MINOR PARTS	0303	DMAS Criteria/DMAS Provider Manual
L7520	REPAIR PROSTHETIC DEVICE, LABOR COMPONENT, PER 15 MINUTES	0303	DMAS Criteria/DMAS Provider Manual
L7600	PROSTHETIC DONNING SLEEVE, ANY MATERIAL, EACH	0303	DMAS Criteria/DMAS Provider Manual
L7900	VACUUM ERECTION SYSTEM	0303	DMAS Criteria/DMAS Provider Manual
L8000	BREAST PROSTHESIS, MASTECTOMY BRA	0303	DMAS Criteria/DMAS Provider Manual
L8001	BREAST PROSTHESIS, MASTECTOMY BRA, WITH INTEGRATED BREAST PROSTHESIS FORM,	0303	DMAS Criteria/DMAS Provider Manual
L8002	BREAST PROSTHESIS, MASTECTOMY BRA, WITH INTEGRATED BREAST PROSTHESIS FORM,	0303	DMAS Criteria/DMAS Provider Manual
L8010	BREAST PROSTHESIS, MASTECTOMY SLEEVE	0303	DMAS Criteria/DMAS Provider Manual

L8015	EXTERNAL BREAST PROSTHESIS GARMENT, WITH MASTECTOMY FORM, POST MASTECTOMY	0303	DMAS Criteria/DMAS Provider Manual
L8020	BREAST PROSTHESIS, MASTECTOMY FORM	0303	DMAS Criteria/DMAS Provider Manual
L8030	BREAST PROSTHESIS, SILICONE OR EQUAL	0303	DMAS Criteria/DMAS Provider Manual
L8031	BREAST PROSTHESIS, SILICONE OR EQUAL, WITH INTEGRAL ADHESIVE	0303	DMAS Criteria/DMAS Provider Manual
L8032	NIPPLE PROSTHESIS, REUSABLE, ANY TYPE, EACH	0303	DMAS Criteria/DMAS Provider Manual
L8035	CUSTOM BREAST PROSTHESIS, POST MASTECTOMY, MOLDED TO PATIENT MODEL	0303	DMAS Criteria/DMAS Provider Manual
L8039	BREAST PROSTHESIS, NOT OTHERWISE SPECIFIED	0303	DMAS Criteria/DMAS Provider Manual
L8040	NASAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN	0303	DMAS Criteria/DMAS Provider Manual
L8041	MIDFACIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN	0303	DMAS Criteria/DMAS Provider Manual
L8042	ORBITAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN	0303	DMAS Criteria/DMAS Provider Manual
L8043	UPPER FACIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN	0303	DMAS Criteria/DMAS Provider Manual
L8044	HEMI-FACIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN	0303	DMAS Criteria/DMAS Provider Manual
L8045	AURICULAR PROSTHESIS, PROVIDED BY A NON-PHYSICIAN	0303	DMAS Criteria/DMAS Provider Manual
L8046	PARTIAL FACIAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN	0303	DMAS Criteria/DMAS Provider Manual
L8047	NASAL SEPTAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN	0303	DMAS Criteria/DMAS Provider Manual
L8048	UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT, PROVIDED BY A NON-PHYSICI	0303	DMAS Criteria/DMAS Provider Manual
L8049	REPAIR OR MODIFICATION OF MAXILLOFACIAL PROSTHESIS, LABOR COMPONENT, 15 MI	0303	DMAS Criteria/DMAS Provider Manual
L8310	TRUSS, DOUBLE WITH STANDARD PADS	0303	DMAS Criteria/DMAS Provider Manual
L8320	TRUSS, ADDITION TO STANDARD PAD, WATER PAD	0303	DMAS Criteria/DMAS Provider Manual
L8330	TRUSS, ADDITION TO STANDARD PAD, SCROTAL PAD	0303	DMAS Criteria/DMAS Provider Manual
L8400	PROSTHETIC SHEATH, BELOW KNEE, EACH	0303	DMAS Criteria/DMAS Provider Manual
L8410	PROSTHETIC SHEATH, ABOVE KNEE, EACH	0303	DMAS Criteria/DMAS Provider Manual
L8415	PROSTHETIC SHEATH, UPPER LIMB, EACH	0303	DMAS Criteria/DMAS Provider Manual
L8417	PROSTHETIC SHEATH/SOCK, INCLUDING A GEL CUSHION LAYER, BELOW KNEE OR ABOVE	0303	DMAS Criteria/DMAS Provider Manual

L8420	PROSTHETIC SOCK, MULTIPLE PLY, BELOW KNEE, EACH	0303	DMAS Criteria/DMAS Provider Manual
L8430	PROSTHETIC SOCK, MULTIPLE PLY, ABOVE KNEE, EACH	0303	DMAS Criteria/DMAS Provider Manual
L8435	PROSTHETIC SOCK, MULTIPLE PLY, UPPER LIMB, EACH	0303	DMAS Criteria/DMAS Provider Manual
L8440	PROSTHETIC SHRINKER, BELOW KNEE, EACH	0303	DMAS Criteria/DMAS Provider Manual
L8460	PROSTHETIC SHRINKER, ABOVE KNEE, EACH	0303	DMAS Criteria/DMAS Provider Manual
L8465	PROSTHETIC SHRINKER, UPPER LIMB, EACH	0303	DMAS Criteria/DMAS Provider Manual
L8470	PROSTHETIC SOCK, SINGLE PLY, FITTING, BELOW KNEE, EACH	0303	DMAS Criteria/DMAS Provider Manual
L8480	PROSTHETIC SOCK, SINGLE PLY, FITTING, ABOVE KNEE, EACH	0303	DMAS Criteria/DMAS Provider Manual
L8485	PROSTHETIC SOCK, SINGLE PLY, FITTING, UPPER LIMB, EACH	0303	DMAS Criteria/DMAS Provider Manual
L8499	UNLISTED PROCEDURE FOR MISCELLANEOUS PROSTHETIC SERVICES	0303	DMAS Criteria/DMAS Provider Manual
L8500	ARTIFICIAL LARYNX, ANY TYPE	0303	DMAS Criteria/DMAS Provider Manual
L8505	ARTIFICIAL LARYNX REPLACEMENT BATTERY / ACCESSORY, ANY TYPE	0303	DMAS Criteria/DMAS Provider Manual
L8507	TRACHEO-ESOPHAGEAL VOICE PROSTHESIS, PATIENT INSERTED, ANY TYPE, EACH	0303	DMAS Criteria/DMAS Provider Manual
L8509	TRACHEO-ESOPHAGEAL VOICE PROSTHESIS, INSERTED BY A LICENSED HEALTH CARE PR	0303	DMAS Criteria/DMAS Provider Manual
L8510	VOICE AMPLIFIER	0303	DMAS Criteria/DMAS Provider Manual
L8511	INSERT FOR INDWELLING TRACHEOESOPHAGEAL PROSTHESIS, WITH OR WITHOUT VALVE,	0303	DMAS Criteria/DMAS Provider Manual
L8512	GELATIN CAPSULES OR EQUIVALENT, FOR USE WITH TRACHEOESOPHAGEAL VOICE	0303	DMAS Criteria/DMAS Provider Manual
L8513	CLEANING DEVICE USED WITH TRACHEOESOPHAGEAL VOICE PROSTHESIS, PIPET, BRUSH, OR	0303	DMAS Criteria/DMAS Provider Manual
L8514	TRACHEOESOPHAGEAL PUNCTURE DILATOR, REPLACEMENT ONLY, EACH	0303	DMAS Criteria/DMAS Provider Manual
L8515	GELATIN CAPSULE, APPLICATION DEVICE FOR USE WITH TRACHEOESOPHAGEAL VOICE	0303	DMAS Criteria/DMAS Provider Manual
L8600	IMPLANTABLE BREAST PROSTHESIS, SILICONE OR EQUAL	0303	DMAS Criteria/DMAS Provider Manual
L8609	ARTIFICIAL CORNEA	0303	DMAS Criteria/DMAS Provider Manual
L8610	OCULAR IMPLANT	0303	DMAS Criteria/DMAS Provider Manual
L8612	AQUEOUS SHUNT	0303	DMAS Criteria/DMAS Provider Manual

L8613	OSSICULA IMPLANT	0303	DMAS Criteria/DMAS Provider Manual
L8614	COCHLEAR DEVICE/SYSTEM	0303	McKesson InterQual® (subset/product to be determined with posting)
L8615	HEADSET/HEADPIECE FOR USE W/ COCHLEAR IMPLANT DEVICE, REPL	0303	McKesson InterQual® (subset/product to be determined with posting)
L8616	MICROPHONE FOR USE W/ COCHLEAR IMPLANT DEVICE, REPLACEMENT	0303	McKesson InterQual® (subset/product to be determined with posting)
L8617	TRANSMITTING COIL FOR USE W/ COCHLEAR IMPLANT DEVICE, REPL	0303	McKesson InterQual® (subset/product to be determined with posting)
L8618	TRANSMITTER CABLE FOR USE W/ COCHLEAR IMPLANT DEVICE, REPL	0303	McKesson InterQual® (subset/product to be determined with posting)
L8619	COCHLEAR IMPLANT EXTERNAL SPEECH PROCESSOR, REPLACEMENT	0303	McKesson InterQual® (subset/product to be determined with posting)
L8621	ZINC AIR BATTERY FOR USE W/ COCHLEAR IMPLANT DEVICE, REPL EACH	0303	McKesson InterQual® (subset/product to be determined with posting)
L8622	ALKALINE BATTERY FOR USE W/ COCHLEAR IMPLANT DEVICE, ANY SIZE, REPL	0303	McKesson InterQual® (subset/product to be determined with posting)
L8623	LITHIUM BATTERY FOR USE W/ COCHLEAR IMPLANT	0303	McKesson InterQual® (subset/product to be determined with posting)
L8624	LITHIUM ION BATTERY FOR USE W/ COCHLEAR IMPLANT	0303	McKesson InterQual® (subset/product to be determined with posting)
L8627	LUNATE IMPLANT	0303	DMAS Criteria/DMAS Provider Manual
L8628	CARPUS IMPLANT	0303	DMAS Criteria/DMAS Provider Manual
L8629	SCAPHOID IMPLANT	0303	DMAS Criteria/DMAS Provider Manual
L8630	METACARPOPHALANGEAL JOINT IMPLANT	0303	DMAS Criteria/DMAS Provider Manual
L8631	METACARPAL PHALANGEAL JOINT REPLACEMENT, TWO OR MORE PIECES, METAL (E.G.,	0303	DMAS Criteria/DMAS Provider Manual
L8641	METATARSAL JOINT IMPLANT	0303	DMAS Criteria/DMAS Provider Manual
L8642	HALLUX IMPLANT	0303	DMAS Criteria/DMAS Provider Manual
L8658	INTERPHALANGEAL JOINT IMPLANT	0303	DMAS Criteria/DMAS Provider Manual
L8680	IMPLANTABLE NEUROMUSCULAR STIMULATOR ELECTRODE EACH	0303	DMAS Criteria/DMAS Provider Manual
L8681	PATIENT PROGRAMMER (EXTERNAL) FOR USE WITH IMPLANTABLE PROGRAMMABLE	0303	DMAS Criteria/DMAS Provider Manual
L8682	IMPLANTABLE NEUROSTIMULATOR RADIOFREQUENCY RECEIVER	0303	DMAS Criteria/DMAS Provider Manual
L8683	RADIOFREQUENCY TRANSMITTER (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR	0303	DMAS Criteria/DMAS Provider Manual
L8684	RADIOFREQUENCY TRANSMITTER (EXTERNAL) FOR USE WITH IMPLANTABLE SACRAL ROOT	0303	DMAS Criteria/DMAS Provider Manual

L8685	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, SINGLE ARRAY, RECHARGEABLE,	0303	DMAS Criteria/DMAS Provider Manual
L8686	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, SINGLE ARRAY, NON-RECHARGEABLE,	0303	DMAS Criteria/DMAS Provider Manual
L8687	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, DUAL ARRAY, RECHARGEABLE, INCLUDES	0303	DMAS Criteria/DMAS Provider Manual
L8688	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, DUAL ARRAY, NON-RECHARGEABLE,	0303	DMAS Criteria/DMAS Provider Manual
L8689	EXTERNAL RECHARGING SYSTEM FOR IMPLANTED NEUROSTIMULATOR, REPLACEMENT ONLY	0303	DMAS Criteria/DMAS Provider Manual
L8690	AUDITORY OSSEOINTEGRATED DEVCICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS	0303	DMAS Criteria/DMAS Provider Manual
L8691	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, REPLACEMENT	0303	DMAS Criteria/DMAS Provider Manual
L8692	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, USED WITHOUT	0303	DMAS Criteria/DMAS Provider Manual
L8699	PROSTHETIC IMPLANT, NOT OTHERWISE SPECIFIED	0303	DMAS Criteria/DMAS Provider Manual
L9900	ORTHOTIC AND PROSTHETIC SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANO	0303	DMAS Criteria/DMAS Provider Manual
S0189	TESTOSTERONE PELLET, 75MG	0304	DMAS Criteria/DMAS Provider Manual
S1040*	**CRANIAL REMOLDING ORTHOSIS, RIGID, WITH SOFT INTERFACE MATERIAL, CUSTOM**	0302	McKesson InterQual DME
S2083	ADJUSTMENT OF GASTRIC BAND DIAMETER VIA SUBCUTANEOUS PORT BY INJECTION OR	0302	DMAS Criteria/DMAS Provider Manual
S3820	COMPLETE BRCA1 AND BRCA2 GENE SEQUENCE ANALYSIS FOR SUSCEPTIBILITY TO BREAST	0302	McKesson InterQual® Care Planning;Molecular Diagnostics BRACanalysis
V2510	CONTACT LENS, GAS PERMEABLE, SPHERICAL, PER LENS	0304	DMAS Criteria/DMAS Provider Manual
V2520*	**CONTACT LENS, HYDROPHILIC, SPHERICAL, PER LENS**	0304	DMAS Criteria/DMAS Provider Manual
V2599	CONTACT LENS, OTHER TYPE	0304	DMAS Criteria/DMAS Provider Manual
V2799	VISION SERVICE, MISCELLANEOUS	0304	DMAS Criteria/DMAS Provider Manual
0420	Physical Therapy (P.T.), General	0204	McKesson InterQual® Rehab and Chiropractic
0430	Occupational Therapy (O.T.), General	0204	McKesson InterQual® Rehab and Chiropractic
0440	Speech Language Pathology, General	0204	McKesson InterQual® Rehab and Chiropractic
	DMAS Criteria/DMAS Provider Manual - may incorporate CMS Nationally Recognized Criteria		
	Procedure code with * and bolded require authorization effective April 1, 2012		